IN THE SUPREME COURT OF IOWA

No. 19-2137

WILLIAM MCGREW and ELAINE MCGREW,

Plaintiffs-Appellants,

vs.

EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.,

Defendants-Appellees

APPEAL FROM THE IOWA DISTRICT COURT
IN AND FOR BLACK HAWK COUNTY
THE HONORABLE KELLYANN M. LEKAR, JUDGE

AMENDED APPENDIX

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IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW Plaintiffs, v. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D. Defendant.	)	NO. _____ **PETITION AT LAW**

COME NOW the Plaintiffs, and for their cause of action against the Defendants, state as follows:

PARTIES

1. Plaintiffs William and Elaine McGrew are husband and wife and reside in Waterloo, Black Hawk County, Iowa.

2. Defendant Eromosele Otoadese is a medical doctor who practices in Waterloo, Black Hawk County, Iowa.

3. Defendant Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. is an Iowa Professional Corporation that at all times relevant employed Dr. Otoadese.

4. Defendant Driss Cammoun is a medical doctor who practices in Waterloo, Black Hawk County, Iowa.

ALLEGATIONS OF FACT

5. In the summer of 2014, William McGrew began to experience occasional foggy vision in his left eye.

6. On July 25, 2014, Mr. McGrew went to see an ophthalmologist at Mauer Eye Center who found that Mr. McGrew had a cataract that may explain his foggy vision.

7. However, Dr. Mauer thought it appropriate to first rule out a vascular cause for his symptoms, so the doctor ordered a bilateral carotid duplex ultrasound.

8. The carotid ultrasound was performed on August 6, 2014 and was interpreted by Dr. Mauer to show “mild carotid stenosis” of the arteries.

9. Dr. Mauer then proceeded to schedule cataract surgery for Mr. McGrew for approximately August 20, 2014.

10. In the interim, Mr. McGrew was referred by his primary care physician to Dr. Otoadese to determine if the problem he was experiencing was due to a vascular condition.

11. On August 18, 2014, Dr. Otoadese saw Mr. McGrew and ordered a CT angiogram.

12. The CT angiogram was performed on August 18, 2014 and was interpreted by Dr. Cammoun as showing 65% stenosis of the right internal carotid artery.

13. Dr. Otoadese then read and interpreted the CT angiogram to show severe (at least 70%) stenosis of the right carotid artery.

14. Dr. Otoadese was aware of the interpretation of the CT angiogram by Dr. Cammoun and relied upon it in deciding whether to recommend surgery.

15. Dr. Otoadese then advised Mr. McGrew to cancel the cataract surgery and recommended a right carotid endarterectomy to remove the plaque in that artery.

16. Based on the recommendation made by Dr. Otoadese, Mr. McGrew agreed to undergo a right carotid endarterectomy.

17. The surgery was performed by Dr. Otoadese on September 2, 2014.

18. The morning following the procedure, Mr. McGrew awoke with a facial droop and weakness on his left side.

19. An MRI was performed which showed a stroke on the right side of the brain.

20. Dr. Otoadese then returned Mr. McGrew to the operating room in an effort to re-vascularize the area, but that effort was not successful.

21. The stroke suffered by Mr. McGrew was a direct result of the surgical procedure recommended and performed by Dr. Otoadese.

22. On September 26, 2014, Mr. McGrew was seen by Dr. Ivo Bekavac, a Waterloo neurologist, for a second opinion regarding his condition.

23. Dr. Bekavac, who has special training in interpreting imaging related to carotid arteries, examined Mr. McGrew and reviewed the pre-surgery imaging, and concluded that there was insufficient pre-surgery carotid stenosis to justify the September 2, 2014 surgery.

24. Dr. Bekavac also concluded that the second surgery was not indicated as the symptoms of the stroke had occurred more than 8 hours before.

25. Dr. Bekavac then sent the imaging studies to Dr. John Halloran, a Waterloo diagnostic radiologist, and asked him to review them to determine whether he concurred with Dr. Bekavac's interpretation of the imaging studies.

26. Dr. Halloran's review of the pre-surgery imaging confirmed Dr. Bekavac's conclusion that there was not sufficient evidence to justify the recommendation and performance of the September 2, 2014 surgery.

27. The surgery of September 2, 2014 was an unnecessary surgical procedure that unnecessarily placed Mr. McGrew at substantial risk for the stroke that he eventually developed.

28. The interpretation of the pre-surgery imaging studies by Dr. Cammoun and Dr. Otoadese were incorrect, and the decision to recommend surgery by Dr. Otoadese was also wrong.

29. The Defendants failed to provide that degree of skill, care, and learning ordinarily possessed and exercised by other doctors, specialists, and hospitals in similar circumstances.

30. The Defendants' conduct constitutes medical negligence and breach of fiduciary duty, including lack of informed consent.

31. The conduct of the Defendants was a cause of the injuries and damages sustained by Plaintiffs.

COUNT I

1. Plaintiff William McGrew has sustained harms and losses, including, but not limited to, past and future physical and mental pain and suffering, permanent loss of full body, medical expenses, future medical expenses and loss of income.

2. William McGrew's damages exceed the jurisdictional requirements of Rule 6.105 of the Iowa Rules of Appellate Procedure.

WHEREFORE, Plaintiff William McGrew prays for judgment against the Defendants for a reasonable amount of actual damages sufficient to fully compensate him and for interest and costs as provided by law.

COUNT II

1. Plaintiff Elaine McGrew has sustained harms and losses, including, but not limited to, the loss of services, support, companionship, society, and consortium of her husband.

2. Plaintiff Elaine McGrew's damages exceed the jurisdictional requirements of Rule 6.105 of the Iowa Rules of Appellate Procedure.

WHEREFORE, Plaintiff Elaine McGrew prays for judgment against the Defendants for a reasonable amount sufficient to fully compensate her and for interest and costs as provided by law.

Respectfully submitted,

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IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW Plaintiffs, v. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D. Defendant.	)	Case No. LACV130355 **PLAINTIFFS' DESIGNATION OF EXPERTS**

COME NOW the Plaintiffs and hereby designate the following persons who may be called as expert witnesses at the time of trial in the above referenced matter:

1. Dr. Carl Warren Adams
   101 Becket Lake Dr. @ Celadon
   Durango, CO 81301-8853

Dr. Adams is a Board Certified Cardiovascular and Thoracic Surgeon including Trauma and Surgical Critical Care. Dr. Adams will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Adams' education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which is being provided to counsel.

2. Dr. Ivo Bekavac
1735 W. Ridgeway Ave., Suite 112
Waterloo, Iowa 50701

Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Bekavac's education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which has been provided to counsel.

3. Dr. John Halloran
1825 Logan Ave.
Waterloo, Iowa 50701

Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

A professional summary of Dr. Halloran's education, training, experience, and qualifications to testify as an expert witness can be found at the website for UnityPoint Health: www.unitypoint.org/waterloo. A CV may be provided later.

4. Kent Jayne
502 Augusta Circle
North Liberty, Iowa 52317

Mr. Jayne is a Certified Life Care Planner, vocational rehabilitation specialist and an economist who has been asked to develop a life care plan for Bill McGrew and can then testify to the amount of money needed to fund that life care plan. Depending on how the court rules on the issue of a lien for medical expenses, he may be asked to determine what medical bills are related to the injuries and damages sustained by Bill McGrew due to the negligence of the defendants.

Mr. Jayne's education, training, experience, and qualifications are as set forth in his curriculum vitae, which is being provided to counsel.

The following witnesses are "experts" in that they have scientific, technical or other specialized knowledge. However, these individuals (like Dr. Bekavac and Dr. Halloran) have not been retained in anticipation of litigation, and their expert opinions, if any, have not been developed in anticipation of litigation, but rather arise from the fact that these individuals may be treating physicians to the Plaintiff or have such other connection to this litigation that they are fact witnesses with specialized expertise.

5. All of Bill McGrew's treating health care providers as disclosed in the

discovery process. This includes all individuals disclosed in depositions including the defendants.

6. All other providers of services, assistive devices, educational care, custodial care and rehabilitative care as disclosed in the discovery process.

7. Plaintiffs reserve the right to call any other treating health care provider to testify to Bill McGrew's health history and potentially to causation and damages.

8. Plaintiff reserves the right to utilize, as experts, those individuals designated by the defendants in their designation to the Court.

9. Plaintiff reserves the right to call any rebuttal expert witnesses to any expert witness designated by defendants that raise issues otherwise not anticipated or expected.

Respectfully submitted,

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IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,** **Defendants**	)	**NO. LACV130355** **PLAINTIFFS' BRIEF IN RESISTANCE TO MOTION FOR SUMMARY JUDGMENT**

COME NOW the Plaintiffs and hereby submit their Brief in Resistance to Dr. Cammoun's Motion for Summary Judgment:

INTRODUCTION

This lawsuit arises out of a surgery to remove plaque (cholesterol buildup) from Bill McGrew's right carotid artery. Plaintiffs contend that the surgery was unnecessary and that as a result of this unnecessary surgery Bill McGrew was subjected to unnecessary risk resulting in his suffering a stroke caused by the unnecessary surgery.

There are two defendants in this case: Dr. Otoadese, the surgeon who recommended and performed the fateful surgery; and Dr. Cammoun, the radiologist who misread the CT angiogram that was relied upon by Dr. Otoadese in recommending surgery.

The issue before the court is Defendant Cammoun's motion for summary judgment based on the mistaken belief that plaintiffs have failed to produce an expert report as required by Iowa Rule of Civil Procedure 1.500(2)(b). Dr. Cammoun's argument then claims that, because an expert report has not been produced, Plaintiffs

Cammoun does not demonstrate right carotid artery stenosis of 65%. Rather, Dr. Halloran contends that the correct reading of that CT angiogram is 32% and Dr. Bekavac contends that the correct reading of that CT angiogram is no more than 40%. Dr. Bekavac also opined that because the CT angiogram was misread there was no justification for the surgery that was performed on Mr. McGrew. Accordingly, Plaintiffs complied fully with the disclosure requirement of IRCP 1.500(2)(c).

Defendant's contention that Plaintiffs were obligated to provide an expert report pursuant to the retained expert disclosure rule is simply mistaken. Defendant concedes that Drs. Bekavac and Halloran were treating physicians. As such, Plaintiffs had no obligation to obtain a written report from each. In fact, that's contrary to the entire framework of the disclosure requirements. The intent and purpose of the rules is to recognize that, when it comes to treating physicians, Plaintiffs have little to no control over those individuals. That is totally different than the scenario in which Plaintiffs go out and hire or retain an expert for the purpose of testifying at trial. In that scenario, Plaintiffs can obtain a report prepared by the retained expert. Treating physicians are not required to prepare special reports because they've not been retained for that purpose. Rather, treating physicians can rely upon any progress notes or medical records that they have generated themselves in the care and treatment of the plaintiff and can rely on the mental impressions they developed during the treatment process and any opinions formed from the facts obtained and impressions made.

The Iowa rules recognize that treating physicians can develop mental impressions and opinions arising out of the care and treatment that they provide. That is certainly what happened here regarding Drs. Bekavac and Halloran. They are not

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COME NOW the Plaintiffs and submit the following proposed jury instructions for consideration by this Court. Plaintiffs reserve the right to add, change or otherwise place before the Court jury instructions after the taking of testimony or introduction of evidence.

Respectfully submitted,

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INSTRUCTION NO. 11

LOSS OF CHANCE OF A BETTER OUTCOME

If you find that the McGrews have failed to prove their claim for medical negligence as set forth in Instruction No. 8 and their claim for inadequate informed consent, you must then consider the McGrews' alternative claim for lost chance of a better outcome.

If you find that plaintiffs have proven either their claim of medical negligence or their claim for inadequate informed consent, you should not consider plaintiffs' alternative claim for lost chance of a better outcome.

In order to prove their claim for lost chance of a better outcome, the McGrews must prove all the following propositions:

1. Dr. Otoadese was negligent in failing to return Bill McGrew to surgery immediately upon learning that Bill was showing signs or symptoms of a stroke.

2. The negligence caused a loss of a chance of a better outcome.

3. The amount of damage.

If the McGrews have proved all these propositions, the McGrews are entitled to damages in some amount. If the McGrews have failed to prove any of these propositions, the McGrews are not entitled to damages on this claim.

ICJI 1600.16 (modified to fit case)

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Defendants Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. (sometimes collectively "Dr. Otoadese") move, prior to selection of the jury and outside the presence of the jury for an Order prohibiting Plaintiffs, their witnesses, and attorneys from directly or indirectly making any statements, giving any evidence, or asking any questions during the selection of the jury, opening statements, presentation of the evidence (including cross examination of a witness called by Defendants), or closing arguments relating to the matters enumerated below until the Court has the opportunity to rule on the admissibility thereof. Defendants further move the Court to order Counsel to advise their clients and each witness called by them regarding the Court's limitation on evidence and testimony to this Motion. Defendants so move on the grounds that if the matters enumerated herein are mentioned it would be so prejudicial that Defendants would not receive a fair trial and an admonition to the jury would not cure the prejudice.

Defendants move in limine on the following: [1]

[1] The following are attached:
Exh. 1 Report and Deposition of Plaintiff's expert Dr. Adams
Exh. 2 Plaintiff Mr. McGrew Deposition

1. Any evidence regarding, or references to, an informed consent theory of recovery.

Plaintiffs' proposed instructions indicate the intent to introduce evidence regarding an informed consent claim as an alternative if the jury fails to find Dr. Otoadese negligent. Expert testimony is required for aspects of an informed consent claim which are beyond the common everyday knowledge of a lay jury—and Plaintiffs do not have the needed expert support for their informed consent theory. The claim is unsupportable and related evidence and references should be excluded under Rules 5.402 and 5.403. It would be unfairly prejudicial for Plaintiffs to expose the jury to a theory of recovery and plant seeds of doubt and suspicions about a theory that cannot survive.

Plaintiff William McGrew suffered a stroke after a carotid endarterectomy surgery performed on September 2, 2014 by Dr. Otoadese. Plaintiff's only expert, surgeon Dr. Adams, agrees that a stroke is a known complication of the surgery even when the surgery is performed without negligence. Exh. 1 at 13 (Dep. 39:9-21). There is no dispute that Mr. McGrew was informed prior to surgery of the risk of a stroke. Exh. 2 at 2 (Dep. 8:7-24). In addition to his deposition testimony, Mr. McGrew signed a consent form, indicating he had been told of the risks. There are no allegations in this case that Dr. Otoadese negligently performed the surgery.

Before the carotid surgery, Defendant radiologist Dr. Cammoun (who has settled with Plaintiffs) interpreted an August 18, 2014 diagnostic CT angiogram as showing 65% stenosis on the right and 60% stenosis on the left. *See* Exh. 1 at 2 (Adams report at 2). Dr. Otoadese, while not a radiologist and relying on Dr. Cammoun's interpretation, documented the stenosis as 70%

Exh. 3 Plaintiff Elaine McGrew Deposition
Exh. 4 Dr. Otoadese's deposition
Exh. 5 Dr. Bekavac's Sept. 26, 2014 record
Exh. 6 Dr. Halloran Oct. 1. 2014 record
Exh. 7 Plaintiff's 2nd Supp. Ans to Interrogatory No. 16, 12-18-18

on the right. Exh. 4 at 26 (Dep. 92:1-94:7). Dr. Otoadese recommended surgery. Exh. 4 at 27 (Dep. 96:24-97:16).

Plaintiffs' expert, Dr. Adams, disagrees that surgery was indicated. He opines that the surgery was not necessary because the CT angiogram (sometimes referred to as "CTA") did not show sufficient blockage in the carotid artery to warrant surgery. Exh. 1 at 3 (report at 3 ¶4: "Mr. McGrew did not meet surgical indications for right carotid endarterectomy . . . as the stenosis was less than 40%."). Dr. Adams also opines that "[t]reatment is dual antiplatelet therapy (DAPT) and if surgical criteria is met, i.e., a stenosis of greater than 70% elective right carotid endarterectomy with patch is performed." Exh. 1 at 3 (report at 3, ¶3).

During his deposition, under examination by Plaintiffs' counsel, Dr. Adams was asked to assume he was the physician and then asked what he would tell the patient. Dr. Adams testified that because "there isn't anything documented on the CTA that would make me recommend surgery . . . I'd treat him with aspirin and Persantine or Plavix for anti-platelet therapy for three to six months and reevaluate." Exh. 1 at 16 (Dep. 51:17-52:7). In other words, Dr. Adams' opinion about alternative medication treatment is in the context of his view that the CT angiogram did not support surgery.

Dr. Adams does not opine or explain that--if Dr. Otoadese was correct in determining that surgery was necessary--then Dr. Otoadese still should have informed Mr. McGrew of an alternative to surgery. No where does Dr. Adams describe an alternative medication treatment as an available option if surgery is necessary. It is too late now for Plaintiffs to add more opinions from Dr. Adams.[2]

Plaintiffs' medical negligence jury instruction proposes that the jury could find:

[2] *See* Iowa Rule 1. 508(3) (party must supplement expert disclosures "no later than 30 days before trial").

1. Dr. Otoadese was negligent in one or more of the following ways:

   a. Misreading the amount of stenosis in the right carotid artery on the CT angiogram of August 18, 2014; OR

   b. Performing an unnecessary surgery on Bill McGrew's right carotid artery on September 2, 2014

Plaintiffs' instruction No. 8.[3] Plaintiffs propose that if they fail to prove the above that the jury could then consider the alternative claims for "inadequate informed consent . . . and loss of chance of a better outcome." *Id.* Plaintiffs' informed consent instruction proposes the claim as concerning "The existence of material information concerning an alternative to surgically removing ulcerated plaque in his right carotid artery." *Id.* at No. 10.

Plaintiff's informed consent theory is not supported by expert evidence. The claim is triggered only if Plaintiffs fail to prove Dr. Otoadese was negligent (in other words, if the jury finds Dr. Otoadese was right and surgery *was* necessary). Dr. Adams did not opine that when surgery is necessary that medication therapy is a reasonable alternative to offer the patient. There is no expert testimony about medication alternatives when surgery is necessary.[4]

Stated differently, if surgery was "necessary," how can there be an informed consent claim based upon the failure to tell the patient of an alternative to surgery? The surgery was either necessary or not; Mr. McGrew either met the surgical criteria or not. Submitting Plaintiff's alternative informed consent claim could lead to an inconsistent verdict.

To the extent Plaintiffs suggest they do not need expert testimony to support the informed consent claim, this is not the case. Notwithstanding "the patient rule," informed

[3] Defendants do not suggest they agree with Plaintiffs' proposed instructions.

[4] Submission of issues without evidentiary support constitutes error. *See Manno v. McIntosh*, 519 N.W.2d 815, 823 (Iowa Ct. App. 1994). "Proposed instructions must be supported by the pleadings and substantial evidence in the record." *Wolbers v. Finley Hospital*, 673 N.W.2d 728, 732 (Iowa 2003); *Kohles v. Mercy Health Serv.*, 2010 WL 3894447 *10 (Iowa Ct. App. 2010) (affirming trial court's refusal to instruct on specific allegation "because it concluded there was no expert testimony as to breach of standard of care or as to causation").

consent claims are established with expert testimony. See *Pauscher v. Iowa Methodist Med Ctr*, 408 N.W.2d 355, 360 (Iowa 1987)("the patient ordinarily will be required to present expert testimony relating to the nature of the risk and the likelihood of its occurrence, ..."); *see also Doe v. Johnston*, 476 N.W.2d 28, 31 (Iowa 1991) ("the burden rests with the plaintiff to establish by expert testimony the nature of the risk involved and the likelihood of its occurrence."); *Kennis v. Mercy Hosp. Medical Center*, 491 N.W.2d 161, 166 (Iowa 1992) ("Recently, we held that a claim of lack of informed consent is an issue beyond the common knowledge of laypersons and requires expert evidence;" referring to *Cox*); *Cox v. Jones*, 470 N.W.2d 23, 26 (Iowa 1991) ("without expert evidence, plaintiffs cannot show that defendants did not inform Cox of the existence of a material risk before undergoing the cataract removal operation").

While this case involves the alleged failure to provide material information as to an alternative to surgery rather than the risks of surgery, that does not change the need for expert testimony. In *Anderson v. Iowa Dermatology Clinic,* 819 N.W.2d 408, 416 (Iowa 2012) the Court analyzed a fraudulent concealment claim under informed consent law where the allegation concerned the failure to inform the patient about differences in qualifications between a dermatologist and board-certified pathologist in evaluating a specimen. The context was whether the patient would have chosen an alternative—a review by a pathologist—if given more information. *Id.* In this context, the Court found the plaintiff failed to provide sufficient expert testimony and failed to generate a fact issue. While the plaintiff provided an expert affidavit discussing differences in training, the expert did not "address the nature of the risk . . .

or the likelihood of its occurrence" from having a dermatology review rather than pathology review. *Id.* at 417.[5]

Similarly, here, while Plaintiffs' expert Dr. Adams provides some opinion as to alternative treatments, he does *not* provide information upon which Plaintiffs' informed consent claim is based—that a medication alternative is an option when surgery is necessary. Nor does Dr. Adams provide any opinion as to the likelihood of risks—i.e. the comparison of risks of medication versus surgery for a patient who meets the surgery criteria. *See also Kennis,* 491 N.W.2d at 166 (discussing "comparative risk" in medical decision-making as "not so obvious as to be within the comprehension of a layperson"). A lay jury does not have the needed background to determine, without the assistance from expert testimony, the available alternatives to any given medical procedure or recommendation.

There is insufficient timely disclosed expert evidence to submit an informed consent claim and the claim could lead to an inconsistent verdict. Evidence about, and references to, such a claim should be excluded under Rules 5.402 and 5.403.

2. Any evidence regarding, or references to, a lost chance theory of recovery.

Plaintiffs' proposed instructions also reflect an alternative lost chance claim. This, like the alternative informed consent claim, is not supported by expert testimony and should be excluded. In addition, the lost chance claim was not pleaded and it is not supported under Iowa law.

In addition to Plaintiffs' claim that the carotid endarterectomy surgery was not necessary and should not have been performed, Plaintiffs claim that a second surgery—after Mr.

[5] In *Doe*, the Court addressed a physician's obligation to offer a patient alternatives but did not discuss the need for expert testimony. 476 N.W.2d at 31-32. However, it was clear in *Doe* that there was indeed ample expert evidence on the available alternatives. *Id.* at 31 ("every physician testifying acknowledged . . . the known and available alternative").

McGrew's stroke symptoms occurred—"should have been performed immediately." Exh. 1 at 3 (Adams' report at 3 ¶6). In his deposition, Dr. Adams was asked about this opinion:

> Q: What specifically would have been different in Mr. McGrew's outcome if surgery would have been done earlier?
>
> A: To a reasonable degree of medical certainty and/or probability he would not have suffered a left hemispheric stroke.

Exh. 1 at 16 (Dep. 50:7-11).

The above is not an opinion to support a lost chance theory, but an opinion of traditional negligence. It is an "all or nothing" opinion; not an opinion supporting an alternative claim for lost chance. *See DeBurkarte v. Louvar*, 393 N.W.2d 131, 135 (Iowa 1986)(discussing lost chance theory, comparing it to traditional negligence claim which treats causation as "'an all-or-nothing proposition'"). A lost chance claim requires "[e]xpert testimony . . . to show the defendant's actions probably caused a reduction in the plaintiff's chance of a cure." *Susie v. Family Health Care of Siouxland,* 2018 WL 5848998 *6 (Iowa Ct. App. 2018) (citing *DeBurkarte*). Given Dr. Adams' opinion, Plaintiffs' position that if they fail to prove a medical negligence case, they can ask the jury to still find for them on a lost chance theory is flawed.

A lost chance theory is available in cases where a plaintiff cannot establish causation because the death or injury is attributable to a pre-existing condition—such as cancer. *See Mead v. Adrian*, 670 N.W.2d 174, 186 (Iowa 2003) ("The loss of chance doctrine was created only to allow recovery when traditional negligence principles, particularly causation, preclude recovery . . .") (J. Cady, concurring). The purpose of the doctrine was essentially to relieve a plaintiffs' causation burden when the plaintiff cannot establish causation given the patient's pre-existing condition. *See id* at 181-82 (J. Cady, concurring).

As a threshold matter, Plaintiffs' proposed instructions omit the required language that it is when a plaintiff cannot establish *causation* that a plaintiff might be entitled to an alternative lost chance theory. *See* Iowa Uniform Instructions No. 1600.16 (introductory language: "If you find that plaintiff has failed to prove the second proposition of his claim for negligence [the causation element] . . . you must then consider plaintiff's alternative claim for lost chance of survival."); *id.* Note (in the traditional negligence instruction, the jury is instructed "If the plaintiff has failed to prove . . . causation, you will consider plaintiff's alternative claim for lost chance . . ."). Plaintiffs conveniently omitted the uniform language that a lost chance claim is triggered—if at all—when a plaintiff fails to prove causation. This is telling and demonstrates Plaintiffs are attempting to obtain an advantage by submitting alternative claims --and get multiple bites of the apple with the jury—when those alternative claims do not apply. [6]

As indicated above, Plaintiffs' expert does *not* support a lost chance theory. He unequivocally opines that if Dr. Otoadese had performed the second surgery earlier, Mr. McGrew would not have suffered a stroke. This opinion supports a traditional negligence claim—not a lost chance claim.

In addition, the jury would be speculating to determine the percentage of lost chance without the assistance of expert testimony on this issue—and there is no such testimony in this

[6] Nor do Defendants agree with Plaintiffs' proposed lost chance instruction or theory that if the jury determines a percentage of lost chance greater than 50%, Plaintiffs would be entitled to "all damages" without reduction. *See* Plaintiffs' proposed instruction No. 11B. Plaintiffs are equating a 51% lost chance to a preponderance of the evidence under a traditional negligence claim. Defendants know of no Iowa authority supporting that a lost chance theory—even if the lost chance is over 50%--converts the claim back into a traditional all-or-nothing negligence claim and the right to full damages. Instead, if a jury awards damages under a lost chance theory, it is because the jury did not find traditional negligence and damages are some percent of traditional negligence damages. *See Mead*, 670 N.W.2d at 180 *("*The nature of a claim for lost chance of survival is such that *it must be proportionally less* than a recovery for traditional wrongful-death damages for the same decedent in the same case.") (emphasis added); *id.* at 185 (J. Cady, concurring, explaining that lost chance applies even if the lost chance is less than 50% [which obviously implies the lost chance reduction applies when the lost chance is over 50%]).

case.[7] While *Mead* suggests expert evidence is not required as to the percentage, *see* 670 N.W.2d 174 n.5, it is impossible to determine precisely what evidence supported the lost chance theory in *Mead*. To allow a lay jury to determine the percentage of a lost chance completely on their own without guidance from an expert is contrary to voluminous Iowa law that expert testimony is required for complex medical issues. *See* Defendants' trial brief; *see also Miranda v. Said*, 2012 WL 2410945 *9-10 (Iowa Ct. App. 2012) *affirmed* by 836 N.W.2d 8 (Iowa 2013)[8] (affirming trial court's directed verdict on lost chance theory as jury would be speculating on damages: "the jury had only speculation on which to base any estimation or approximation of the damage claimed").

The alternative lost chance claim should also be excluded because it is not supported by Iowa law. The lost chance theory contemplates that a jury may "fail to find on the evidence that a negligent act was a proximate cause of a patient's death yet believe that *the negligence* deprived the patient of a chance to survive." *Mead*, 670 N.W.2d at 180 (emphasis added). In other words, the alternative claim is based upon the same alleged act of negligence. Here, Plaintiffs' "alternative" lost chance claim is based upon a different alleged negligent act—a delay in returning Mr. McGrew to surgery.

Finally, Plaintiffs did not plead a lost chance theory or give any notice to Defendants prior to submission of their trial pleadings on February 7, 2019 that they were relying on the theory. While *Wendland v. Sparks,* 574 N.W.2d 327, 329 (Iowa 1998) found that a plaintiff was not required to allege a specific loss-of-chance theory in their petition under Iowa's notice-

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[7] *Compare DeBurkarte v. Louvar*, 393 N.W.2d 131, 135 (Iowa 1986)) (describing plaintiff's expert evidence that to "a reasonable degree of medical certainty the plaintiff's chances of surviving ten years would have been [50 to 80 %]" if the cancer was timely diagnosed but such chances had dropped to 0% by trial).

[8] The Iowa Supreme Court did not address the Court of Appeals decision on lost chance damages.

pleading rules, the court found the plaintiff *otherwise* made the claim known to the defense. In *Wendland,* the court found the plaintiff "made it clear" it was relying on the lost chance theory during the course of the case, including with an expert witness opinion supporting the theory and in resistance to a motion for summary judgment. *Id.* There was no notice in this case until less than 3 weeks before trial that Plaintiffs would attempt to submit this alternative theory of recovery. That is too late to allow Defendants a fair opportunity to respond and prepare for this claim at trial and allowing the claim will prejudice Defendants. [9]

3. Any testimony or other evidence from treating health care providers that exceeds the proper scope of such testimony or constitutes inadmissible hearsay, including but not limited to after-the-fact non-treatment opinions of Dr. Bekavac and Dr. Halloran.

Plaintiffs designated two physicians as experts under the category of treating physicians—neurologist Dr. Ivo Bekavac and radiologist Dr. John Halloran. Plaintiffs have never provided signed expert reports for either physician. Under the Iowa Supreme Court's opinion in *Hansen v. Central Iowa Hospital Corp*, 686 N.W.2d 476 (Iowa 2004), evidence from these physicians, if allowed at all, must be limited to opinions formed for the purposes of care and treatment. Further, given these physicians' reports are not entirely treatment records, Defendants do not agree a hearsay exception applies to the records, in whole or in part.

As discussed above, Mr. McGrew had a CT angiogram on August 18, 2014, which was interpreted by radiologist Dr. Cammoun as showing 65% stenosis on the right and 60% stenosis on the left. Dr. Otoadese documented the stenosis at 70% on the right. Mr. McGrew had a carotid endarterectomy on September 2, 2014 and suffered a stroke the next day.

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[9] *See, e.g., Klein v. Chicago Central & Pacific Railroad Co.,* 596 N.W. 2d 58, 61 (Iowa 1999) (purpose of pretrial procedures and discovery rules is to "avoid surprise to litigants and to allow the parties to formulate their positions on as much evidence as is available."); *Trade Professionals Inc. v Shriver*, 661 N.W. 2d 119, 121-22 (Iowa 2003)(party would be prejudiced by the admission of a physician's report, produced approximately seven days *before* a hearing, even though the defendant knew of the existence of the physician).

On September 26, 2014, well *after* Mr. McGrew had the carotid surgery, Mr. McGrew saw neurologist Dr. Bekavac for a "second opinion." Exh. 5. Dr. Bekavac writes:

> [The CTA] was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is approximately 40%. . . . Prior to surgery patient was asymptomatic. . . . The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.
>
> . . .
> IMPRESSION:
> 1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.
> 2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.
> . . .
> 3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discrepancy between my review and Dr. Cammoun review. . . .

Exh. 5. Dr. Halloran authored a review of the CT angiogram and opined the right carotid has 32% diameter stenosis. Exh. 6.

Neither Dr. Bekavac nor Dr. Halloran stated in their records that Dr. Otoadese or Dr. Cammoun breached the standard of care, were negligent, or that their negligence caused Mr. McGrew's stroke. *See* Exh. 5-6. Neither stated any opinions as to the applicable standard of care for Dr. Otoadese or Dr. Cammoun. However, Plaintiffs have indicated that "Dr. Bekavac will testify as to the standard of care [and] causation," including that "The first and therefore the second endarterectomy were unnecessary and violated the standard of care." Exh. 7 at 3. Plaintiffs continue that Dr. Bekavac will be "asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages." *Id.* Almost as an

after-thought, Plaintiffs indicate Dr. Bekavac will also be "asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke." *Id.*

As to Dr. Halloran, Plaintiffs describe that "Dr. Cammoun and Dr. Otoadese misread the CTA and violated the applicable standard of care. . . . He will also be asked to comment on the standard of care . . . , any breach of that standard of care, and the cause-and-effect relationship between the breach . . . and any damages." Exh. 7 at 3-4.

Given Plaintiffs' interrogatory answer, it is clear that they intend to attempt to introduce unlimited expert testimony from Drs. Bekavac and Halloran at trial-- testimony on the applicable standard of care, its breach in this case, and causation. This is all without disclosing a written expert report for these physicians. Plaintiffs must not be allowed to do so.

First, even assuming all the information in these physicians' records is otherwise admissible (which it is not), the physicians do *not* offer any opinions on the applicable standard of care, that it has been breached, or that a breach had a causal connection to Mr. McGrew's stroke. They simply do not state these opinions. *See* Exh. 5-6. Dr. Bekavac's statement that the "stenosis was not significant to justify endarterectomy *in my opinion*" (emphasis added) is not sufficient to establish a standard of care or its breach. His "opinion" may not reflect the standard of care. *See also Kush v. Sullivan*, 2013 WL 4437077 *5 (Iowa Ct. App. 2013) (refusing to extrapolate from treating physician's statements that defendant physician's "work fell below a professional norm" or breached the standard of care). Standard of care and breach opinions have never been disclosed from these physicians and are not admissible. *See* Rule 1.517(3).[10]

[10] Rule 1.517(3) provides "If a party fails to provide information or identify a witness as required by rule 1.500, 1.503(4), or 1.508(3), the party is not allowed to use that information or witness to supply evidence on a motion, at a hearing, or at a trial, unless the failure was substantially justified or is harmless."

Further, for any treating health care provider for whom Plaintiffs did not provide written expert opinions (including Dr. Bekavac and Dr. Halloran), their testimony is limited under *Hansen v. Central Iowa Hospital Corp*, 686 N.W.2d 476 (Iowa 2004). Only those opinions that the treating health care provider formed in the course of his or her care and treatment, if any, are admissible; those formed in a role analogous to an expert are not. *See id* at 484. [11]

In *Hansen*, the Court held causation opinions from a treating physician were admissible notwithstanding the failure to designate the expert or produce an expert report. This is because those opinions were developed during treatment. The Court described the applicable rule for when a treating physician's opinion testimony is admissible without an expert report. The "paramount criterion" is whether the treating physician's opinion "'relates to facts and opinions arrived at by a physician in treating a patient or whether it represents expert opinion testimony formulated for purposes of issues in pending or anticipated litigation.'" 686 N.W.2d at 482 (citation omitted).

The "reason and timeframe in which the underlying facts and opinions were acquired" is critical in determining if the treating physician is focusing less on medical questions and more on legal questions. *Id.* at 483 (citation omitted). "[E]ven treating physicians may come within the parameters of rule 125 [now Rule 1.508] when they begin to assume a role in the litigation analogous to that of a retained expert." *Id.*; *see also Morales v. Miller*, 2012 WL 222527 *8 (Iowa Ct. App. 2011) (testimony was beyond the scope of treatment when physician "had to be

[11] While inconsistent with the records of Drs. Bekavac and Halloran, Plaintiffs described a similar rule (without citing *Hansen)* in their resistance brief to Dr. Cammoun's summary judgment motion. See Brief at 4, filed Jan. 8, 2019 ("treating physicians . . can rely on the mental impressions they developed during the treatment process"); *see also id.* at 7 (describing physicians' records as detailing opinions "formulated at the time they provided care and treatment"). Thus, Plaintiffs seem to agree that the treating physicians are limited to opinions formed *during care and treatment.*

briefed on what happened;" plaintiff failed to demonstrate opinions were reached while physician was treating plaintiff).

Here, Dr. Bekavac and Dr. Halloran's records demonstrate--on their face--that they did not formulate their opinions as part of treatment. The opinions as to interpretation of the CT angiogram and indications for surgery were *after* the surgery--a retrospective review of care. Both physicians assumed roles analogous to a retained expert. In addition, standard of care opinions are rarely--if ever--developed in the course of treatment. *See Hansen*, 686 N.W.2d at 482, 484 (treating physicians are not ordinarily required to formulate standard of medical care opinions in the course of treatment). As the Court in *Hansen* noted--in the absence of a disclosed opinion--"an opposing party should . . . be able to expect that a treating physician's testimony will not include opinions on reasonable standards of care." *Hansen*, 686 N.W.2d at 482.

Plaintiffs have relied upon Rule 1.500(2) that provides a non-retained expert need not provide a signed written report but that the party need only provide a summary of the witnesses expected testimony. Rule 1.500(2) does not overturn *Hansen.* Recent Iowa appellate cases continue to apply the law set forth in *Hansen* notwithstanding Rule 1.500(2). *See Sherrick v. Obstetrics & Gynecology Specialists, P.C.*, 2018 WL 5846055 *4 (Iowa Ct. App. 2018) (affirming exclusion of treating physician's testimony on "performing ultrasounds" as it "did not relate to the care she provided;" "The treating physician's opinion on the standard of care was expert testimony, and thus improper absent compliance with the required disclosures.") (citing *Hansen*); *Stellmach v. State*, 2017 WL 1735618 *10 (Iowa Ct. App. 2017) ("when a treating physician 'assumes a role in litigation analogous to the role of a retained expert,' supplemental discovery may become obligatory").

Iowa law on the scope of a treating physician's opinions that can be admitted at trial in the absence of an expert report is set forth in *Hansen*. Therefore, Plaintiff's choices as to Dr. Halloran and Dr. Bekavac were: 1) retain them and produce reports so Plaintiffs could rely upon them for non-treatment opinions; or 2) be limited to treatment opinions. Plaintiffs did not retain the physicians or produce reports for them and must be limited to treatment opinions.

Dr. Halloran's report and testimony should be excluded in its entirety as Plaintiffs cannot establish his interpretation of the CT angiogram was reached during care or treatment. Plaintiffs were required to disclose an expert report to use such an opinion and did not. While Dr. Bekavac is a treating physician, Plaintiffs cannot establish that his interpretation of the CT angiogram and opinions as to the two carotid surgeries were formed to treat Mr. McGrew. Dr. Bekavac's report demonstrates, instead, that he had taken on a role analogous to an expert. His opinions must be limited to that which arises from his care and treatment of Mr. McGrew.

In addition, Defendants do not waive hearsay exceptions to the records from Dr. Bekavac and Dr. Halloran.

4. Any evidence regarding, or reference to, the irrelevant and unfairly prejudicial subjects discussed below.

There are numerous collateral and extraneous issues in this case that have consumed time in depositions and discovery. The subjects are not relevant to the medical issues and would be unfairly prejudicial if introduced. They would likely mislead the jury, waste time, and create hostilities or suspicions among jurors against Dr. Otoadese. The subjects should be excluded. *See* Rules 5. 402 and 5. 403. In addition, many of the subjects concern references to other litigation, settlements, and insurance. *See* Rule 5.408, 5.411*; see also* ¶5 below; *State of Iowa v. Henderson,* 696 N.W.2d 5, 10-11 (Iowa 2005) (evidence is unfairly prejudicial when it "'appeals to the jury's sympathies, arouses its sense of horror, provokes its instinct to punish, or

triggers other mainsprings of human action that may cause a jury to base its decision on something other than the established propositions in the case'"); *State of Iowa v. Langley,* 2005 WL 1965866 at * 5 (Iowa Ct. App. 2005) (evidence is unfairly prejudicial if it "'would cause the jury to base its decision on something other than the proven facts and applicable law, such as sympathy for one party or a desire to punish a party'").

Plaintiff's motion to compel filed against Dr. Cammoun on August 9, 2018, which has now been withdrawn, explains some context. Plaintiffs sought information to explore the business relationship between Dr. Cammoun and Dr. Otoadese. Plaintiffs argued:

> Dr. Otoadese has testified that he has been prevented from performing cardiac surgery by the local hospital and has been terminated from his former clinic group. A reasonable conclusion from this is that he has been affected financially and therefore may be more willing to consciously or subconsciously consider a more expensive procedure for Mr. McGrew. Dr. Otoadese has described being very close friends with Dr. Cammoun. And it turns out that Dr. Otoadese has a lease relationship with an entity partly owned and principally managed by Dr. Cammoun.

Plaintiffs' motion at ¶9. The motion to compel has been withdrawn, Dr. Cammoun will be dismissed, and Plaintiffs have not pursued this discovery.

a. That it is "rare," unprecedented, or similarly uncommon for one physician (i.e. Dr. Bekavac or Dr. Halloran) to criticize another.

In depositions and other context, Plaintiffs' counsel characterizes Dr. Bekavac and Dr. Halloran's records as criticizing another physician and as "rare" --implying there are worthy of emphasis and notice. Plaintiffs' characterization should be excluded--particularly given that much of those "rare" comments should themselves be excluded. *See* ¶3 above; Rules 5.402, 5.403.

b. Dr. Otoadese's past professional relationship with Cedar Valley Specialists, including references that he was "kicked out," "fired," or "terminated" and it involved the loss of insurance.

There were deposition questions and testimony that Dr. Otoadese was "kicked out," "fired," or terminated from Cedar Valley Medical Specialists. Exh. 4 at 6, 8 (Dep. 14, 22). Dr. Otoadese explained the departure included a lawsuit, settlement out of court, and a decision that he was performing high-risk procedures and not insurable. Exh. 4 at 8 (Dep. 22-23). This event--however characterized--occurred before any care and treatment of Mr. McGrew. Plaintiffs' only medical expert makes no connection between any such events and the care provided. *See* Rules 5. 402, 5.403, 5.408, 5.411

c. The fact that Dr. Otoadese no longer has privileges to do open heart surgery at Allen Hospital and a related lawsuit (including Defense expert Dr. Levett's involvement).

There was deposition testimony that Dr. Otoadese no longer does open heart surgery at Allen. Plaintiffs' counsel characterized it as under the "insistence of the hospital." Dr. Otoadese explained that it was "political," "even resulted in a lawsuit and was settled out of court," was not "straightforward," and his ceasing to do open heart surgery was "negotiated." Exh. 4 at 7 (Dep. 16-18). Plaintiffs also deposed Defense expert Dr. Levett on this subject as Dr. Levett served as an expert for Allen hospital. The discussion with Dr. Levett included that the dispute involved cardiac surgery privileges. Dr. Cammoun also resigned privileges from Allen hospital.

This case does not involve heart surgery or hospital privileges. Plaintiffs' only retained expert offers no opinion about Dr. Otoadese's qualifications or privileges. This subject is not relevant. It would introduce complicated and prejudicial collateral issues into the case that would only detract from the medical issues and likely confuse the jury. If introduced, it would require response time from the defense. The subject involves matters of other litigation and likely would require explanation of peer review--both subjects that should be excluded on their own merit. *See* Rules 5. 402, 5.403, 5. 408; ¶ 5, 6.

d. That Dr. Cammoun's business entity leases space to Dr. Otoadese.

Dr. Cammoun explained that his entity, ADI, leases space to Dr. Otoadese for him to do ultrasounds. This has no relevance whatsoever, particularly now that Dr. Cammoun will be dismissed. *See also* ¶4(e) below; Rules 5. 402, 5.403.

e. Suggestions that there was a financial motive behind Dr. Otoadese's care decisions.

As explained above, Plaintiffs counsel has attempted to create or imply a financial motive to Dr. Otoadese. After discussion of Dr. Otoadese's cessation of open heart surgery, it was implied Dr. Otoadese lost much of his practice--somehow suggesting that recommending surgery to Mr. McGrew was financially motivated. Exh. 4 at 7-8 (Dep. 19-22). When asked about an ultrasound on Mr. McGrew, Dr. Otoadese explained that he did not repeat the test as there would be no reimbursement--but since he was ordering a CT angiogram anyway, a repeat ultrasound "did not matter." Exh. 4 at 19-20 (Dep. 67-68). In ordering the CT angiogram, Dr. Otoadese testified he prefers studies done at ADI ("Advanced Diagnostic Imaging"), which is Dr. Cammoun's business, because it a local radiologist. Exh. 4 at 22 (Dep. 76-79). There was also evidence that Plaintiffs were charged a "no show" fee at Dr. Otoadese's office--unknown to Dr. Otoadese. Exh. 4 at 17 (Dep. 56-58).

These discrete pieces of evidence may be strung together by Plaintiffs to attempt to vilify Dr. Otoadese. But any speculative and fabricated theory of a financial motive is not relevant to the medical care. Plaintiffs' expert does not suggest otherwise. Further, the theories and speculations would be highly prejudicial to Defendants, creating the distinct possibility of a jury verdict on an improper basis. *See* Rules 5. 402, 5.403.

f. The fact that the entire medical record was not produced to Plaintiffs initially.

In Dr. Otoadese's deposition, Plaintiffs asked why an August 18, 2014 initial consult was not produced initially by his office-- which was unknown to Dr. Otoadese. Exh. 4 at 18 (Dep. 61-63). *See* Rules 5. 402, 5.403.

g. Suggestions about personal relationships among physicians, including Dr. Otoadese, prior Defendant Dr. Cammoun, Dr. Bekavac, and Dr. Halloran.

Dr. Otoadese testified about friendships, professional relationships, and socializing among the physicians --and that it has changed over time. Exh. 4 at 8-9 (Dep. 23-26). Plaintiffs counsel asked Dr. Otoadese to essentially speculate why Dr. Bekavac and Halloran would write the reports they did and if Dr. Otoadese had confronted them. Exh. 4 at 29 (Dep. 104-106).

Again, Plaintiffs' medical expert provides no basis for this subject to be relevant. It is not. Its only use would be to create hostility or suspicions. Rules 5. 402, 5. 403.

h. That Dr. Otoadese took the board certification test two times to pass.

Dr. Otoadese is board certified and testified he took the exam two times the first time. Exh. 4 at 10 (Dep. 28). The number of times a physician takes a board certification exam many years before the care and treatment involved in a case is not relevant. If relevant at all, its probative value is outweighed by the danger of unfair prejudice. Plaintiffs' expert offers no opinion that Dr. Otoadese is not qualified or sufficiently trained or experienced. Rule 5. 402, 5.403.

5. Any reference to, or evidence concerning, other patients, claims, patient complications or adverse outcomes, or lawsuits involving Dr. Otoadese.

As explained above, there have been other suits mentioned in discovery, including with Cedar Valley Specialists and Allen Hospital. These and any other medical malpractice action should be excluded. Such evidence of, or even reference to, other suits, claims, and patient complications is inadmissible under Rule 5.402; should be excluded as prejudicial and resulting

in a confusion of issues under Rule 5.403; and should be excluded as "other wrongs or acts" evidence under Rule 5.404(b).

Even if evidence about other patients or lawsuits was relevant (which it is not), it should be excluded under Rule of Evidence 5.403. The admission of such evidence would result in waste of time on collateral issues, create undue delay, and mislead the jury. Furthermore, any possible probative value of this evidence is substantially outweighed by the unfair prejudice to Defendants.

Other courts have held that, in the context of medical malpractice, other incidents and other medical malpractice suits, are not relevant, are highly prejudicial, and should not be admitted. *See Lai v. Sagle,* 818 A.2d 237, 247-48 (Ct. App. Md. 2003).

> The fact of prior litigation has little, if any, relevance to whether [the physician] violated the applicable standard of care in the immediate case. The admission of evidence of prior suits, instead of aiding the fact finder in its quest, tends to excite its prejudice and mislead it. . . .[We] cannot conceive of a more damaging event, in a medical malpractice trial, than disclosure to the jury in opening argument that the defendant doctor had previously been sued multiple times for malpractice.

818 A.2d at 247 (finding trial court abused its discretion in not granting a mistrial for improper opening argument); *id.* at 246 (also finding such evidence "is not probative of a physician's professional qualifications, or lack thereof"); *see also Cerniglia v. French,* 816 So.2d 319, 324-35 (La. Ct. App. 2002) (finding trial court erred in allowing testimony of physician's former patients who suffered similar complications as plaintiff as testimony was not probative on negligence or physician's knowledge and skill and evidence was too prejudicial even if probative as it allowed jury to make improper inferences).

Such evidence is also inadmissible under Iowa Rule of Evidence 5.404, under which a party typically cannot introduce character evidence or evidence of "other wrongs or acts" to prove that a person acted in conformity therewith.

6. Any reference to, or evidence concerning, peer review; credentialing; privileging; morbidity and mortality monitoring; or other investigations, evaluations, or charges (if any) involving Defendant, the Iowa Board of Medical Examiners, or another entity or individual.

To the extent Plaintiffs attempt to elicit testimony, make references to, or introduce documents that pertain in any way to peer review or other evaluative activities (whether pertaining to this case or to Defendant in general), such evidence is not relevant to any claim. Evaluative or investigative type evidence, or reference to such activity, would also be highly prejudicial to Defendants—carrying a negative connotation. The evidence is inadmissible under Rules 5.402 and 5.403, statutory and regulatory peer review privileges, and Iowa case law. *See* Iowa Code §147.135(2); Iowa Code §135.40 and .42.

7. Any testimony regarding, or references to, alleged out-of-court statements by health care providers (other than Dr. Otoadese).

The depositions of Plaintiffs revealed many out-of-court statements by health care providers (other than Dr. Otoadese). Such statements are inadmissible hearsay. See Rule 5.802.[12]

They are also inadmissible under Rule 5. 403. Plaintiffs have a medical expert to provide testimony on the medical issues in this case. The jury is not to make a determination of medical

[12]Such statements would not be admissible under 5.803(4) "Statement for purposes of medical diagnosis or treatment." That exception applies to statement made by patients *to* their health care providers—not the other way around. The rationale for the rule is that "a statement made in the course of procuring medical services, where the declarant knows that a false statement may cause misdiagnosis or mistreatment, carries special guarantees of credibility." *State v. Mann*, 512 N.W.2d 528, 535-36 (Iowa 1994) (citation omitted); Fed. R. Evid. 803(4) Advisory Committee Note (exception applies to statements that the *patient* makes to health care providers, not statements made by health care providers); *Carbonnell v. Bluhm*, 318 N.W.2d 659, 664 (Mich. Ct. App. 1982) ("The rule in MRE 803(4) does not apply to statements by the doctor regarding the patient's physical condition.").

negligence or causation based upon a layperson's understanding and then repetition of what a health care provider said. It would be highly prejudicial and inconsistent with expert rules applicable to medical malpractice cases for Plaintiffs to introduce Plaintiffs' restatement of what they understood on medical issues. Upon hearing such hearsay, the jury could find against Defendants—not because there was evidence of a breach of the applicable standard of care—but because of this hearsay.

Without limiting the scope of this limine request, Defendants identify the following hearsay statements that should be excluded:

a. Mr. McGrew testified three unidentified cardiologists (two from Mayo and one from Waterloo) told him he didn't need surgery and could be cured by aspirin. Exh. 2 at 7 (Dep. 27).

b. Mrs. McGrew testified Dr. Hassani told her there was a two hour window after the stroke for return to surgery. Exh. 3 at 10 (Dep 39: 19-24).

c. Elaine McGrew testified that Dr. Halloran told her daughter [double hearsay] that the blockage was not sufficient for surgery. Exh. 3 at 19-20 (Dep. 76:22-77:4).

d. Elaine McGrew testified that Dr. Bekavac told her that surgery was unnecessary. Exh. 3 at 19 (Dep 74:1-12)..

The jury should hear directly from experts or testifying treating health care providers on these subjects, if at all—not lay witnesses who attempt to recall what they remember and then repeat it as best as possible.

8. Any evidence regarding, or references to, future medical expenses (or life care expenses) other than those to be paid by Plaintiffs themselves.

As set forth in Defendants' trial brief, Iowa Code §147.136 applies in this case. That statute provides that damages for economic losses in a medical malpractice case such as this one

are not recoverable if paid or to be paid by insurance, a governmental program, or any other source --other than Plaintiffs or Iowa's Medicaid program under Iowa Code Chp. 249A. Thus, under this statute, a medical malpractice plaintiff typically recovers their only out-of-pocket medical expenses.

In a January 23, 2019 supplemental interrogatory answer, Plaintiffs have indicated they have reached a settlement with United Healthcare Services, Inc "with regard to any lien or subrogation interests it may have arising from this lawsuit." (Plaintiffs previously indicated Medicaid "has indicated that no payments were made."). Accordingly, any past and future medical expenses paid or to be paid by Plaintiffs' health plan (United Healthcare Services, Inc.) are not recoverable. Even assuming that the past and future lien and subrogation interests of United Healthcare Services were enforceable given Iowa Code §147.136, those interests have been satisfied. As such, Plaintiffs' recovery under Iowa law is limited to their future out-of-pocket medical expenses. Evidence about other future medical expenses is not relevant and would be unfairly prejudicial. *See* Rule 5.402, 5.403.

9. Any reference to liability insurance coverage.

It is "generally improper for the subject of liability insurance to be raised in any way before the jury." *Strain v. Heinssen*, 434 N.W.2d 640, 642 (Iowa 1989)(discussing Rule of Evid. 5.411)(citing *Evans v. Howard R. Green Co.*, 231 N.W.2d 907, 914 (Iowa 1975)). The rationale underlying Rule 5.411 is that "evidence of insurance is rarely probative and frequently prejudicial." *Id.* at 642. Such evidence is inadmissible under Rules 5.402, 5.403, and 5.411. See *Strain*, 434 N.W.2d at 643 (refusing to apply exception in Rule 5.411 to allow evidence that an expert was paid by an insurance company for testimony). The Iowa Supreme Court in *Strain*

acknowledged the significant prejudicial impact of insurance evidence and affirmed its exclusion when offered to suggest an expert was biased. *Id.*

10. Any reference to, or evidence concerning, punitive damages, punishing Defendants, or "sending a message" to Defendants or medical providers in general.

Plaintiffs do not have a claim for punitive damages. Any mention of punishing or that the jury should "send a message" to Defendant is irrelevant and would be highly prejudicial. *See* Rules 5.402; 5.403; *Nishihama v. City and County of San Francisco*, 112 Cal. Rptr. 2d 861, 865 (Ct. App. 1st Dist. Div.1 2001) ("Any suggestion that the jury should 'send a message' by inflating its award of damages, however, would be improper . . ." where punitive damages are not submitted).

11. Any reference to the relative size, earning powers, or economic or financial condition of the parties or their law firms, including that Defendants may have more lawyers working on this matter than Plaintiffs.

Any testimony, argument, or evidence that compares the respective earning powers or financial or economic conditions of Plaintiffs and Defendants should be excluded. Plaintiffs should not be permitted to characterize themselves directly or indirectly as the underdog in this case or in any way, imply that the Defendants have the ability to spend more money or devote more resources to the case.[13]

[13] *See Burke v. Reiter*, 42 N.W.2d 907, 912 (Iowa 1950)(affirming grant of new trial for defendant due in part to plaintiff counsel's improper reference to the comparative wealth of parties; "[C]omparison of respective earning powers or financial or economic conditions is entirely improper"); *see also Rosenberger Enterprises, Inc. v. Insurance Serv. Corp. of Iowa*, 541 N.W.2d 904, 907 (Iowa 1995) ("When determining liability it is improper for the jury to consider the relative wealth of the parties."); *Hackaday v. Brackelsburg,* 85 N.W.2d 514, 518 (Iowa 1957) ("Of course we do not approve any reference in argument to the worth or poverty of a litigant . . . ."). "It is prejudicial for a plaintiff to improperly introduce the question of wealth into the trial of a case involving only compensatory damages." *Burke v. Deere & Co.,* 6 F.3d 497, 513 (8th Cir. 1993) (Iowa law), cert. denied, 114 S.Ct. 1063 (citing *Trapalis v. Gershun*, 145 N.W. 2d 591, 596 (Iowa 1966) (noting a large compensatory award can "raise the question whether the jury was improperly influenced" by the evidence of the defendant's wealth).

Nor should Plaintiffs be allowed to refer to the number of lawyers in the undersigns' firm or working on this matter. This topic is irrelevant, prejudicial, and inadmissible under Rules 5.402 and 5.403.

12. Any reference to settlement offers, or lack thereof, and negotiations, including the settlement by Dr. Cammoun.

Any such evidence is inadmissible pursuant to Rule 5.408.

CONCLUSION

For the reasons set forth above, Defendants respectfully request that the Court grant their Motion in Limine.

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CERTIFICATE OF SERVICE
The undersigned hereby certifies that a copy of this document was served upon counsel of record for each party to the action in compliance with Iowa R.C.P. 1.442(b) on: Feb 12 2019
By: ☐ Overnight Courier ☐ FAX ☐ E mailed
☐ Hand Delivered ☐ U.S. Mail ☒ E filed
☐ Certified Mail ☐ Other
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IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, Plaintiffs, vs. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.D., and DRISS CAMMOUN, M.D., Defendants.	NO. LACV130355 Videotaped Deposition of EROMOSELE OTOADESE, M.D.

Videotaped Deposition of EROMOSELE OTOADESE, M.D., taken before Julie M. Kluber, Certified Shorthand Reporter, commencing at 9:32 a.m., March 8, 2018, at 515 Main Street, Suite E, Cedar Falls, Iowa.

Julie M. Kluber, CSR, RMR
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APPEARANCES

Plaintiffs by:	MARTIN A. DIAZ Attorney at Law 1570 Shady Court NW Swisher, IA 52338 and MARK L. CHIPOKAS Attorney at Law 866 First Avenue NE P.O. Box 1261 Cedar Rapids, IA 52406-1261
Defendants Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic by:	JENNIFER E. RINDEN VINCENT S. GEIS Attorneys at Law 115 Third Street SE, Suite 500 P. O. Box 2107 Cedar Rapids, IA 52406-2107
Defendant Cammoun by:	GEORGE L. WEILEIN Attorney at Law 515 Main Street, Suite E P. O. Box 724 Cedar Falls, IA 50613
Videographer:	Josh Goding

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PROCEEDINGS

THE VIDEOGRAPHER: Good morning. We're on the record at 9:32 a.m., March 8, 2018, at the law offices of Weilein and Boller, P.C., in Cedar Falls, Iowa.

EROMOSELE OTOADESE, M.D.,

called as a witness, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DIAZ:

Q. Doctor, could you please introduce yourself by providing us with your full name.
A. Anthony Eromosele Otoadese.
Q. All right. And I understand you like to go by Dr. Tony?
A. Yes.
Q. Okay. Doctor, in front of you is a document marked Exhibit 1, which is -- my understanding is this is your c.v. that was provided to us. Can you look at it and let me know if this is up to date.
A. Yes, it is.
Q. Okay. My understanding is you were born in Nigeria?
A. Yes.

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Q. And what year did you come to the United States?
A. 1971.
Q. And for what purpose did you come to the U.S.?
A. To study.
Q. And what did you want to study when you first came in 1971?
A. I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry.
Q. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978.
A. Yes.
Q. And a chemistry major?
A. Chemistry, yes.
Q. Okay. And then the next thing that I have on your c.v. is that you then went to medical school at the State University of New York Downstate in Brooklyn and got your medical degree in 1987.
A. Yes.
Q. Okay. Your c.v. doesn't tell us what you did between 1978 and 1987. Can you tell us what you did?

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A. I did -- Yeah, I did -- I did graduate work in biochemistry.
Q. So you were a student, then, the entire time or --
A. Yes.
Q. -- only part of that time?
A. No. I was a student the whole time.
Q. So when you came to the United States in 1971, did you come to go to college or -- or was it high school or what was that?
A. I finished high school in Costa Mesa in Califomia, then went to college.
Q. Okay. So pretty much from when you came to the U.S. in 1971 up until 1987, when you start medical school, you are -- you're a student. Correct?
A. Yes. Graduate student, yes.
Q. Right. Both high school, undergrad, graduate, and now you're going to go to medical school.
A. Medical school, yes.
Q. Okay. And then you're in medical school up until 1987, and then from there you do your residency, your fellowship -- I'm sorry, your internship, your residency, and then fellowships that take you all the way up to

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1996. Correct?
A. Yes. Correct.
Q. So essentially you're a student from 1971 up until 1996.
A. Yes.
Q. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics.
A. Yes, I did.
Q. Okay. Now, have you done any additional education other than what we see up through 1996?
A. As far as -- you mean college education or -- or specialty training? I don't understand what the question is.
Q. Sure. So your c.v. takes us all the way up to 1996, and my understanding is that you start working, then, in Waterloo in around 1996?
A. Yes. I finished -- This is the only job I ever had. I finished, I took a job here, and I've been here since then.
Q. Okay. And what I'm interested in knowing is in addition to what you already have on your c.v., is there any additional medical education or training that you've had since 1996?

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A. Over the years, yes. I -- You know, I got into interventional vascular surgery and I took training in this.
Q. So what's interventional vascular work? What is that?
A. Interventional endovascular procedures, using balloons and stents to supplement, to complement the open surgeries that I do.
Q. Okay. So up through 1996 in terms of your training, was your training limited to open type procedures?
A. Open, yes.
Q. And did you start learning endovascular work?
A. After that.
Q. After that.
A. Right.
Q. Okay. And do you list that anywhere on your c.v.?
A. No, you don't -- I don't need to. Just -- It's just not -- I didn't get diplomas or anything from it, so --
Q. Or certificates?
A. No certificates, no.
Q. Well, when you --
A. They're meetings. You go to meetings. Some of

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them a week, some of them two weeks. Hands-on experience and things, yeah.
Q. Okay. And --
A. I did that.
Q. Have you done, then, endovascular work since when? When was the first time you started doing endovascular work?
A. In the '90s maybe. '99, 2000, I don't recollect but around there.
Q. Okay. So where did you get the training necessary that allows you to do that type of work; that is, the endovascular work?
A. All over the country. University of Michigan, Arizona Heart Institute, University of Missouri in Columbus, and various meetings, you know. Texas Heart Institute.
Q. But none of that is on your c.v. Correct?
A. That's correct, yes.
Q. Okay.
A. There is not -- I usually don't list those because, again, I didn't get degrees from there. I just listed places where I got degrees.
Q. Okay. And then in terms of when you go to apply for privileges at a hospital, for

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example, and you say, "I want to do open surgeries like I've been trained to do and I want to do endovascular work like I've been trained to do," do you have to show the hospitals anything there in terms of showing them that you've actually trained in any of this?
A. Well, that's not relevant for me because I've never gone to look for a job somewhere. I've never been faced by that.
Q. Okay. Well, have you done endovascular work in the hospital, let's say -- let's say -- Let's talk about your hospital work here.
A. Yeah.
Q. My understanding is that practically all of your hospital work is at Allen Memorial Hospital. Is that right?
A. Yes, yes.
Q. I think at one time you said it was 99 percent of your work?
A. Yeah. I would say that, yeah.
Q. And I'm not going to hold you to exact percent --
A. That's right.
Q. -- but your point is that almost all of your

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work is there?
A. Yes.
MS. RINDEN: You guys can't talk at the same time. Let him finish.
THE WITNESS: Okay, sorry.
MS. RINDEN: It's all right.
Q. So when it comes to Allen Memorial Hospital, do you share with them, then, this information that says, "I've been trained in endovascular work"? Did you share that information with them?
A. Yes. When I go to training, I come back. If I want to do a new procedure, they require that you go get trained. I come back and I tell them that, yes, I -- I just got back from Arizona Heart Institute and I went to learn endovascular repair of aneurysms, you know, and it's something new that the hospital doesn't do. I'm interested in it, I go learn it, I come back and I do it.
Q. Okay. And my understanding that once you finished your training at University Hospitals and went into private practice, you came to Waterloo and you -- you were with one particular -- I want to call it a clinic. I

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don't know what you would -- what you called it back then, but there were -- it was you and a couple of other colleagues that ran a -- a clinic. What was the name of that clinic?
A. I'm trying to remember. Cardiac Surgery Associates or something like that, yes.
Q. Right. And then at some point Cardiac Surgery Associates merges with Cedar Valley Medical Specialists, Professional Corporation. Correct?
A. Right. It wasn't a merger, but -- but we -- we joined them. We -- we were asked to join them because the cardiologists at the hospital were part of Cedar Valley. We were independent and Dr. John Wiggins, he was the senior partner. He had hired me. He didn't want to join Cedar Valley, he wanted to be independent, but the cardiologists who we work very closely with were part of Cedar Valley, so the hospital administrator said it's -- it's easier and works better if -- when the surgeons and the cardiologists are in the same group. So we were made to join them politically, and that's one reason John left.
Q. Okay. And then my understanding is you were at

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Cedar Valley Medical Specialists from 1999 until 2012 -- through 2012.
A. Yes.
Q. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was -- what was the relationship within that organization?
A. Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly, when you first joined you're not a shareholder but after two years or something you become a shareholder.
Q. Okay. I've seen documents from the secretary of state that show that in 2012, the last year that you were there, that there were 58 different physicians that were part of Cedar Valley Medical Specialists.
A. Yes.
Q. Okay. And that they included Dr. Bekavac, Dr. Halloran, Dr. Cammoun --
A. Yes.
Q. -- and you.
A. Yes.
Q. Correct?

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A. Um-hmm. Yes.
Q. And then my understanding is in 2013, you open up Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C.
A. Yes, I did.
Q. Okay. And actually, the records show that you formally created the company in November of 2012. Is that -- is that about right?
A. Yes, yes.
Q. In anticipation that you're going to start January 1 of 2013. Correct?
A. I don't remember the dates. Yes.
Q. And it's true, isn't it, that you were terminated from Cedar Valley Medical Specialists? I think you described it as they kicked you out. Is that correct?
A. Correct, yes.
Q. Okay. Now, I want to talk about the kind of work that you've done since you started in -- started in private practice in roughly 1996. We talked about you doing open procedures.
A. Yes.
Q. And endovascular work.
A. Yes.
Q. So I want to understand the difference. So

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when you talk about open procedures, what are we talking about there?
A. Open surgery where you -- you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you -- it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're able to do them without opening the abdomen. You could do percutaneous, for example. You go through the groin without making incisions and you put a stent in the aneurysm. That's endovascular.
Q. Okay. And my understanding is that you were doing -- as part of the open procedures, you're doing open -- what you call open heart surgery.
A. Yes.
Q. And I know that some folks don't necessarily use that term "open heart" the way that maybe a layperson might understand it. Can you tell us what that would have consisted of, what you -- What will you be doing if you're doing open heart work?

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A. Heart surgery. Valve replacement, coronary artery bypass grafting, aneurysm resection. You open the chest.
Q. Okay. Now, if you -- If somebody were to come to you today and say, "I want to do open heart" -- "I want you to do an open heart surgery," would you be able to do that on them?
A. I could but I don't do them anymore. I stopped doing open heart in 2009.
Q. I think you've testified in the past that you stopped doing open heart surgeries in 2008 and that you --
A. Okay.
Q. -- voluntarily surrendered your privileges to do open heart surgeries.
A. Yes, I did.
Q. Okay. And that my understanding is that that was at the insistence of the hospital. Is that true?
A. No.
Q. That's not true?
A. No.
Q. All right. So it was your desire all along to just stop doing open heart surgeries in 2008, 2009?

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MS. RINDEN: Well, hold on. I'm going to object to the form. Argumentative.
You can answer, Doctor, if you can.
A. Yes. It's -- I -- I don't know if it's something to be discussed here, but it was political, and -- and it even resulted in a lawsuit and was settled out of court, but it wasn't -- it wasn't that straightforward. It was political, yes.
Q. I understand the concept of political, but the -- but the true answer to my question when I said that the hospital insisted that you stop doing them, that -- that is technically true. Correct?
A. Not correct. It's not.
Q. So the hospital didn't ask you to stop doing open heart surgeries?
A. They did not -- they did not ask -- I did not stop doing open heart surgery because they asked you to.
Q. They told you to.
A. It was negotiated.
MS. RINDEN: Hold on a minute. You guys are talking at the same time, and I'm going to object to form. Argumentative. Let him -- let him -- you finish your answer and then let him finish, Marty.

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A. If you insist that I go into it, it was a political thing, and -- and I wasn't -- I wasn't in agreement with -- with -- with things and I sued the hospital, and that resulted in a lot other things. All I can tell you is that I am still in good standing in the hospital. I do all my surgeries there. I -- I mean I'm still on the -- on the hospital staff in good standing.
Q. Okay. So just to summarize, there was some sort of disagreement between you and the hospital that related to doing open heart surgeries. Your viewpoint is that there was a political decision. Correct?
A. Correct.
Q. It ended up in you filing a lawsuit with some kind of a settlement that's confidential. Correct?
A. Correct.
Q. Okay. All right. The fact is that you've not done open heart surgeries, then, since roughly 2008, 2009. Is that true?
A. 2009, yes.

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Q. Okay. Now, my understanding from looking at things you've said in the past that you were doing in this timeframe of roughly 1999 to 2008 -- I'm going to use that timeframe -- you were doing 50 to 60 percent of all surgeries were open heart surgeries, 30 to 40 percent were vascular surgeries, and 10 to 20 percent was thoracic. Is that true?
A. Noncardiac thoracic.
Q. Okay. So I want to understand what we're talking about. So up until you have this -- this disagreement with the hospital --
A. Yes.
Q. -- 2008, 2009, you're doing about 50 to 60 percent of your work is doing open heart surgeries.
A. I would say so, yes.
Q. Okay. And about 30 to 40 percent is vascular, so what is vascular then?
A. Peripheral vascular, working on arteries and veins.
Q. So in this case with Mr. McGrew where you end up doing a carotid endarterectomy, what is that? Is that a vascular procedure?
A. Vascular.

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Q. Okay. And then 10 to 20 percent would be noncardiac thoracic.
A. Yes.
Q. Meaning what?
A. Lungs, esophagus, you know, anything in the chest other than heart.
Q. Okay. In this timeframe before you stopped doing the open heart surgeries, when you did vascular work, what percentage of your vascular work was open and what percentage was endovascular?
A. I can't -- I can't guess. I can't -- I can't guess. I think most of it was open. But I can't give you percentage.
Q. In reading what you've testified in the past about, I got the impression that you were far more comfortable doing open procedures than you were doing endovascular. Is that a fair statement?
A. In the -- in the beginning, yes, because the open was what I was trained doing.
Q. Right.
A. But I'd say learned more endovascular and got better in it, and I'm just as comfortable doing endovascular now.

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Q. Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time?
MS. RINDEN: I'm going to object to the form. You can go ahead and answer, Doctor.
A. Yes. I would say until -- again, I can't put numbers in it, but all I can tell you that I was the only cardiovascular surgeon in the Cedar Valley up until 2008 or so, so I did all the open heart surgeries. I did most of the vascular surgeries and most of the thoracic surgeries.
Q. Are you able to give me a reasonable estimate of the number of surgeries you would do in a year back then?
A. At one point I was doing over 1,000.
Q. Okay. All right. So if you're losing 50 to 60 percent of your open heart work, does that mean 500 to 600 of those surgeries were lost, meaning you're no longer doing them, or is it not that simple?
A. It's not that simple.
Q. Okay.

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A. Because we were doing them about 300 -- 300 -- two-eighty to 300 hearts, open hearts a year.
Q. They just take longer.
A. Yes.
Q. And so for that reason, 50 percent, 60 percent of your time may be a more appropriate way rather than saying 50, 60 percent of your surgeries.
A. Well, yeah. Yes, I agree with that.
Q. Okay. All right. Now, you have testified in the past that despite your being fired from Cedar Valley Medical Specialists in 2012 that you maintained, quote, "a good working relationship with those folks."
A. Yes.
Q. Okay.
A. Let -- let me back up a little. I don't know about the fired. If you -- if you want to know details of why I left Cedar Valley, I said they kicked me out. Is -- There was a lawsuit. A patient developed a foot drop from vein surgery, which I'd never seen. I do a lot of vein surgery, and there was a lawsuit and they sued -- the lawsuit was settled out of court, and the Cedar Valley organization decided that

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I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the membership, I left in good terms. I -- I got my own insurance, started my own corporation, and I'm still here.
Q. Okay. But -- and I don't want to be unfair to you, Doctor.
A. Okay.
Q. I used the word "fired" as the equivalent of "terminated." You used the word -- This is what you said. You said, "They terminated me. They kicked me out."
A. That's what I'm saying. I'm just clarifying that.
Q. And I appreciate that. I appreciate that. Did you have any -- for example, did you get along with Dr. Bekavac?
A. Yes. I still do, yes.
Q. Okay. Do you get along with Dr. Halloran?
A. Yes. I still do.
Q. Okay. Is there anyone at Cedar Valley with whom you did not have a good working relationship when you left in 2012?

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A. Working relationship, no. I get along with everybody.
Q. Okay. All right. As you sit here, I know you're aware that Dr. Bekavac has written -- he's got a medical record that talks about his viewpoint of what happened with Mr. McGrew. I assume you've had a chance to look at that?
A. Yes, I have.
Q. Okay. And I assume you've seen Dr. Halloran's interpretation of the CT angiogram done on Mr. McGrew on August 18th of 2014?
A. Yes, I have.
Q. I assume you disagree with both of them.
A. Yes, I do.
Q. Okay. Do you have an explanation for why they've taken the position that they've taken?
A. No, I can't -- I can't second-guess them. I don't -- you know.
Q. Do you think there's any bad faith on their part, either one? Any malice or any ill will toward you that would explain why they have taken the position they've taken in these documents?
MS. RINDEN: I'm going to object to the form. It's vague and asking for speculation on

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this doctor's part.
You can go ahead and answer.
A. There was me, I don't think so but they -- they may have disagreement with the -- my co-defendant. I know that, but I know that there's some serious problems between them, but that's not my story to tell.
Q. Okay. Well, I'm interested in that. Is there -- is there something about the relationship between those two -- that is, Dr. Bekavac, Dr. Halloran -- and Dr. Cammoun that we need to know about?
A. I think there is, but it's not my story to tell. You'll be -- you'll be talking to Dr. Cammoun, and if he wants to tell it, he'll tell it because I'd be speculating.
Q. Well, and I appreciate that, Doctor, but if you have information about that -- in other words, if you know it firsthand, meaning you've witnessed some disagreement or you've heard Dr. Bekavac or Dr. Halloran say bad things about Dr. Cammoun, for example, or you've heard Dr. Cammoun say, "These people are out to get me," or anything like that -- and I'm not holding you to specific words -- I guess I'm

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interested in knowing what firsthand information you have.
A. Okay. I don't have firsthand information, but I can tell you from what you have just said that we were all very close friends. Very close, all of us. Cammoun -- Dr. Cammoun, Dr. Bekavac, Dr. Halloran and I. We -- we did things together.
Q. Okay.
A. Especially with Dr. -- especially between -- with -- with Dr. Bekavac. Bekavac, Cammoun, and I, we're very, very close. And Bekavac and Halloran were partners, too, but over the years something has happened that they're no longer partners, and something has happened that we all -- we all don't socialize like we used to be -- like we used to do.
But I don't -- I don't have -- I don't think there's anything personal between -- against me from them, but I do -- I do think that there -- there is between Dr. Cammoun and -- and Dr. Halloran and Dr. Bekavac, but again, it's Dr. Cammoun's story to tell if he wants to tell it.
Q. Okay. All right. So I want to switch subjects

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with you if I can. Historically for you, when it comes to doing removal of plaque from carotid arteries, what has been the technique that you use? Is it an open technique or do you use an endovascular technique or is it both?
A. Both.
Q. What makes the determination for you as to whether you're going to do it open versus endovascularly?
A. Well, they are -- there are anatomic considerations, for example, based on the CT or whatever image and study you do. The -- the -- For example, if the carotid artery is tortuous, then it's not safe to put a stent in it because the stents don't bend, so if it's tortuous, that would be one.
If the aortic arch has this anatomic variation, what is called a type 2 or a type 3 aortic arch, it's not ideal to put a stent in because the way the carotid artery comes -- common carotid artery comes out of the aortic arch, it's not straight and it -- it would be very difficult to make a shunt -- a stent from the groin to get up there. So a type 3 arch

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probably should open rather than stent.
If a patient has had radiation to the neck, for example, and then it's not -- it's not safe to go back there to try to open through the radiation. A patient like that would benefit -- if it can be done, would do better with a stent than open. If it's a redo operation -- in other words, patient has had open carotid before, it's plugged up again and you're going to go back in, and the risk for complications is high if you are doing a redo open procedure. In a patient like that you want a stent because it would be easier, so it depends.
Q. Okay. And are you board certified, Doctor?
A. Yes, I am.
Q. How many times did you have to take the test, the board certification test?
A. The board certification. I'm on my third time around.
Q. I --
A. The first time twice.
Q. Okay. That's what I meant.
A. Yeah.
Q. I was interested in the first time. Okay.

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A. Yes.
Q. And you're recertified, correct?
A. Yes.
Q. Okay. Now, let's talk about the surgery that you did on -- on Mr. McGrew. According to -- I'm going to show you here -- I've got a document marked Exhibit 9.
A. Okay.
MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits.
Q. According to this document, this Exhibit 9, this is the -- this is, by the way, the -- the operative report?
A. Yes.
Q. Okay. You describe the type -- the operation as a right carotid endarterectomy with -- is it vasatek?
A. Vascutek, V A S C U T E K.
Q. Thank you. Carotid patch angioplasty.
A. Yes.
Q. Okay. Let's try to understand. As I understand it, this is an open procedure.
A. Yes.
Q. So you cut in, you expose -- You have to clamp off.

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A. Yes.
Q. You expose the -- the section that you want to remove the plaque from.
A. Yes.
Q. You remove the plaque, and then you put a patch over the area that you've been working on.
A. Yes.
Q. Okay. And the angioplasty is what? What is that?
A. That's the name. It's a patch angioplasty.
Q. Thank you. Okay. So what was its purpose? What were you trying to accomplish with this procedure?
A. Just as you described, to remove the plaque.
Q. Okay. Did you have any difficulty in the procedure itself? In other words, let me give you examples. Did you have any trouble getting access to and visualizing the -- the area where you're working?
A. Not at all.
Q. Did you have any trouble removing the plaque?
A. No.
Q. Did it take too long -- For example, when you clamped off, did it take too long to get access to and remove the plaque and get out and -- and

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take the clamps off?
A. No. Not that I recollect.
Q. Okay. Can -- Mr. McGrew ends up with a -- with a stroke. Correct?
A. Correct.
Q. Now, someone might ask the question what went wrong, so -- and when I ask that, I'm just wanting to know and understand --
A. That's right.
Q. -- what's the relationship between what you did and what happened to Mr. McGrew?
MS. RINDEN: I'm going to object to the form.
You can answer if you can.
A. I don't have an answer. I still -- Till this day I still ask myself what -- what could happen, because I did the operation the same way I've always done them. I still do the operation, the open procedure, the same way. Nothing has changed.
Q. Okay.
A. And I have never had, knock on wood, an outcome like this. So I can't explain it.
Q. All right. Now, it's fair to say that if you were talking to patients about undergoing a

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right carotid endarterectomy with this patch that you're going to explain to them that there are risks associated with doing that surgery.
A. Yes.
Q. Okay. Did you do that here?
A. Yes.
Q. All right. Who did you do that with? In other words, who was present when you talked to Mr. McGrew?
A. Mr. McGrew. His daughter for sure.
Q. Okay.
A. And I think his wife. I'm not sure, but his daughter was there for sure.
Q. And did you know his daughter?
A. Yes.
Q. How did you know his daughter?
A. She works in the office of one of my colleagues.
Q. And who is the colleague?
A. It's in the -- Matt Smith, Dr. Matt Smith.
Q. Okay. All right. So you knew her from that. You sit down and you talk with Mr. McGrew, and you explain to him the risks.
A. Yes.
Q. I assume you explained to him that one of the

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risks of doing this right carotid endarterectomy with this patch is that he could get a stroke.
A. Yes.
Q. All right. Do we know in the -- either in the literature or from your training why it is that some people who undergo this procedure end up with a stroke?
A. No. I don't think there's any way to predict it. No. Just -- No.
Q. Is there a -- Do you have a sense of what your complication rate is -- back in this timeframe of 2014, what your complication rate was related to doing an open right -- doesn't matter whether it's right or left, an endarterectomy?
A. One percent or less.
Q. Okay. All right. Now, it's my understanding that the following day, Mr. McGrew starts to show some symptoms or signs of -- of a possible stroke. Correct?
A. Correct.
Q. So I want to understand your involvement. I know that there was a document that was given to us by your attorney, and I -- honestly, it's

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the best copy I got.
A. Okay.
Q. I'm not saying it's a great copy, but I'm going to show you what's been marked as Exhibit 8. And this is a calendar, because one of the things I asked for was I wanted to know how many surgeries you were doing on this particular day.
A. Okay.
Q. Or procedures. I know that doctors use the term different than maybe that lay people do. Are you able to tell from looking at that document how many different procedures you did on September 2nd of 2014?
A. No. Because it's -- I can't read it. Only -- No.
Q. They're -- look like they're little check marks next to things. Do you see that there?
A. Yes.
Q. Are you able to tell us whether a check mark suggests or indicates one -- a procedure at each time?
A. No. Is this from my office or where -- where is this from?
Q. I can't tell you where it came from. I assume

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it came from your office.
A. Office surgery calendar. No, I don't. I can't tell you.
Q. Okay. Well, let's -- let's look -- let's leave it this way: Could you check with your staff and ask them to look on September 2nd through your records and say -- tell us how many different procedures and the types of procedures you did on that day? Is that something that could be done?
A. You could -- you could get that from the hospital.
Q. Okay. They would have those records too?
A. Yes, they -- they could tell you whether -- you know, what --
Q. Okay.
A. I think that would be better.
Q. Is it customary for you to do just one surgery on one particular day?
A. It depends on how busy we are. Some days I do three or four surgeries, five, depending on -- depends on the operation, the complexity of the operation.
Q. Sure.
A. If I'm doing an abdominal aneurysm repair, I

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can't do more than one or two a day. If I'm doing varicose vein surgery, I can do ten a day. It really depends. Carotid, I've done three in one day.

Q. All right. How long does it typically take you to do this -- the surgery that you performed on Mr. McGrew?

A. Again, it depends on the patient, but typically I would say an hour and a half to two hours.

Q. All right. Do you know how long it took in this case, in his case?

MS. RINDEN: Do you want him to look at the records or --

MR. DIAZ: I'm just asking if -- if he knows. If he doesn't, we can always go look at the records.

A. No, I don't recollect.

Q. All right. Was it your impression that it took roughly the same amount of time that it normally takes, an hour and a half to two?

A. Yeah. I don't -- I don't remember or recollect anything unusual or in particular.

Q. Okay. Now, so tell me, do you have any memory of anything that happened to Mr. McGrew after you were done with his procedure and before

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midnight of that same day?

A. No. I mean typically we're done with the operation, you -- you wake the patient up in the room and make sure there are no deficits they wake up, and then you go to the recovery room. They're in the recovery room for some time. The recovery room nurses determine how long they stay in the recovery room, a lot of other factors, and determines when they leave recovery room. If -- if the patient is doing -- is progressing as expected, then they go from recovery room to their room, whether ICU or the regular floor.

Q. All right.

A. But up until the patient went to the floor, because I went with them -- I -- usually I go with all my patients to the recovery room, and then I -- when they get settled in recovery room I go talk to the family, and then I go to my office, I do whatever else I have to do. And that's -- As far as I know, there was nothing -- there was no -- no complication with me as far as being notified that there was anything going on until the next morning.

Q. And it looks like from the records that around

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somewhere between seven and seven-twenty in the morning, he starts to show some difficulty with facial droop, some drooling, and some difficulty moving the left side of his body. When are you notified of that?

A. I think it's in the record. As soon as -- My -- my understanding is that, at least from reading the records, his daughter had come to pick him up the next day because he was going to be discharged, and I think either she -- he was getting dressed and he wasn't moving very well, and she got a nurse to come in to take a look.

Q. Okay.

A. And the nurse came in and -- and agreed that he was having trouble moving his left leg while he was trying to get dressed. And -- and I think they called me right away to say he was having problems, and -- and I came in.

Q. Okay. And were you able to tell at what time these symptoms had developed, had started?

A. I've looked at the records. I don't -- I can't tell. I just -- You know, I don't know. I can't tell you.

Q. Okay. So let's say you're there at, let's say,

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eight o'clock in the morning, as an example. You're there. I think the records show that there was an Allyson -- is it Landfair?

A. Yes. She's my nurse practitioner.

Q. Yeah. She's one of your staff people. She makes contact with the nurse around seven-forty, so I'm going to use eight o'clock as just an example. Let's say at eight o'clock you're -- you're now aware that this patient has shown some signs or symptoms of possible stroke. What are your -- what are your options at this point? What can you do if, in fact, this patient has a stroke?

A. Well, depending on -- First thing you -- you want to get a study to see -- you know, get a CAT scan. That's the first thing.

Q. Okay.

A. If he has -- Because you want to start -- you want to anticoagulate them but you also -- you want to know if they're bleeding in the brain, and if they are, you don't want to anticoagulate them, so you take them to CAT scan to check for a head bleed.

Q. And the CAT scan in his case showed there was no bleeding.

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A. Right.
Q. Correct? So at that point now you know that, so what are your options at this point with this patient?
A. Well, I was there. I saw him and I saw he -- he had some -- some movement. He -- he wasn't moving very well, but he's -- and -- and because I did not know how long this had been going on -- it may have happened at midnight, we don't know. At that point my -- my option was just to anticoagulate him and watch him. Give him some time.
Q. Okay. All right. If you had known what time it had happened -- for example, when the first symptom had started -- does that somehow change what you can do for the patient?
A. Yes. If he was in recovery room and he -- and he was having these problems, we go right back to surgery.
Q. Okay.
A. If that happened, yes.
Q. Now, I know from reading the records there was a doctor -- a neurologist -- I've got to be honest, I'm going to have a hard time pronouncing that doctor's name.

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A. Hassani, we call him. Hassani.
Q. Hassani? Okay.
A. For short.
Q. That's a -- that's a shortened version of his name.
A. Yeah.
Q. Okay. So Dr. Hassani -- we're going to use that for today -- comes in and he wants -- apparently he wants you to take this patient back to surgery. Is that true?
A. Not immediately. He came in and he wanted an MRI done.
Q. Okay.
A. So patient was taken to MRI and -- and some time transpired and then he called me, yes, and wanted -- suggested that the patient should go back to surgery.
Q. What did that MRI show?
A. I don't recollect. That the carotid was occluded.
Q. Okay. And what did it show in terms of damage to the brain, do you know?
A. I don't recollect.
Q. Okay.
A. You have it there somewhere.

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Q. That's fine. I just want to know if you knew. So at this point after the MRI, you're pretty satisfied that -- that this man has sustained some kind of a stroke, some kind of damage to the brain?
A. Yes.
Q. And so let's forget about Dr. Hassani for a second. Let's talk about you.
A. Yes.
Q. What do you think should be done at that point?
A. Just watch him. Anticoagulate him and watch him to see what function -- what function recovers.
Q. Okay. But Dr. Hassani apparently thinks maybe you should take him back to surgery. Why does he want you to take him back to surgery?
A. I can't --
MS. RINDEN: I'm going to -- Hold on just a second, Doctor; excuse me. I'm going to object to the form. Vague, and it calls for speculation.
You can answer if you know.
Q. Well, Doctor, let me -- I'm not interested in having you speculate. I assume that you would have spoken to Dr. Hassani if Dr. Hassani wants

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you to take this patient back, right?
A. I spoke to him but --
Q. So what did he say to you is what I'm interested in knowing.
A. He just said, you know, I think I should take him -- take him back to try and open up the carotid.
Q. And what did you say to him?
A. I said no. I don't think it's safe to do that at this point.
Q. And why isn't it safe to do that?
A. Because the first place we don't know how -- how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal.
Q. Okay. So your -- your -- your concern is we're already -- we're already dealing with an ischemic stroke.
A. Yes.
Q. That is, there's been blood flow cut off to the brain, which is causing a lack of oxygen and it's killing the brain.

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A. Yes.
Q. Okay. Your concern is if we go back in, we could make this -- turn this into a situation where it starts to bleed into the brain.
A. Yes.
Q. Thereby expanding or -- or compressing what's left in the brain. Correct?
A. Yes. It's fatal.
Q. All right. Now, at some point, and I don't know the time exactly, but maybe we could find it in your records; somewhere I read three o'clock in the afternoon. I'm not particularly focused on the time, I'm more interested in apparently you at some point agree to go back in and do that. Tell me what led you to -- to go back in and do a second surgery on Mr. McGrew.
A. Dr. Hassani called me later on, several hours later, and said that he had spoken to a vascular surgeon at an outside hospital who has agreed to operate on the patient, and he was going to transfer the patient to the hospital -- to another hospital for operation, and at that -- that -- that's -- I disagreed.
I said, "No. I won't" -- "I won't let you

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do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him."
Q. Okay.
A. So I took him.
Q. And so who did you speak to in the family?
A. The family. There were -- there were -- By now there were a bunch of people there.
Q. Okay.
A. I think his wife, his daughter, a few other people. I don't recollect exactly, but --
Q. All right. And I know you're not going to remember everything you told them. I'm not expecting you to, but can you give us an idea of what kinds of things you wanted to share with them in terms of making a decision?
A. Well, I told them that this is not safe, that it could -- it could turn -- it could -- As I have just said, it could turn it into a hemorrhagic stroke that he would not survive,

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and also told them I wasn't certain that taking him back to surgery is going to recover -- is going to make him recover the lost function. If anything, it -- it could make this worse.
Q. Okay. And what was the family's response to this?
A. Well, they agreed -- you know, they agreed they -- they agreed in spite of the risks, so I took him.
Q. Okay. But what was their motive? What was -- what was motivating them to say, "Look, Doctor, we want you to" -- "we want you to go ahead and do this second surgery"? What were they telling you?
A. I can't -- I can't tell you what their motivation was. I do know that I came down to talk to them. You know, there was -- somebody was crying. Everything going on there in the midst of all the confusion, but --
Q. Well --
A. I can't tell you what their motivation was, but --
Q. Well, again, I'm not interested in you having to try to figure out what's in their heads. I'm more interested in knowing what they said

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to you as to why they wanted you to proceed anyway.
A. They didn't say why. They just -- I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back.
Q. And was it your understanding that they had -- They had been speaking to Dr. Hassani, correct?
A. I assume they had been.
Q. Okay. All right. Are you critical at all of the family for asking you to go back and -- and do a second surgery?
A. Not at all, no.
Q. All right. Okay. Did anything happen as a result of the second surgery? In other words, did -- did you go back in and did you create this -- you know, inadvertent necessarily, bleeding? Did anything like that happen during the second surgery?
A. No.
Q. What was the goal of the second surgery? What were you trying to accomplish?
A. To reestablish blood flow to the brain.
Q. Were you able --
A. Because the CAT scan and the MRI had shown the

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artery was occluded, a thrombosis.
Q. Occluded meaning?
A. There was a blood clot there.
Q. So if we -- if we talk in terms of a -- of a highway and you're trying to get through that highway, that highway was completely blocked.
A. Blocked, yeah.
Q. Okay. And were you able to remove -- to create space so that blood could flow through to the brain?
A. Yes.
Q. Do you have an opinion as you sit here as to whether the stroke that Mr. McGrew suffered and the problems that he suffered were related solely to the first surgery or partly related to the second surgery or anything like that?
A. I have no opinion that I -- I -- I don't think that the second surgery hurt anything or improved it. I think nothing changed.
Q. Okay. All right. And do you have an opinion as to what would have happened to him if you chose not to do the second surgery; in other words, left this right carotid artery occluded, how that would have played out in terms of his either getting better or getting worse?

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A. No.
Q. You don't have any opinion.
A. No.
Q. Okay. All right. Now, I don't know whether -- when these conversations took place, but the family recalls having conversations with you in which you indicated -- you know, you sort of shared with them your thought about what had happened, and -- and I don't want to put words in their mouth or yours. I want you -- to get your version of it, and I'm not sure when that occurs, whether it occurs immediately after the stroke is found or after the second surgery or some other day, but I'm interested in finding out from you what you recall about your interaction with the family in talking about what had happened to their -- to Bill.
A. I don't recollect anything. I do recollect talking to the daughter -- to his daughter, I think much later. I saw her in the -- in the hallways. I asked about her dad and how he was coming along, and she said he was in rehab and is -- is okay, stable and, you know, I just -- I -- I encouraged her. I said she should encourage her dad to keep working with therapy.

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We still don't know how much function we get back, you know.
Q. Okay.
A. We've known people who have had stroke, and with hard work and all that were able to get back some function. I said, "Just have him keep working."
Q. All right. Did you ever apologize to the family at any point?
A. Apologize. I don't get -- Apologize for what?
Q. I'm just asking you if you ever apologized. Sometimes people will say, "I'm sorry. I feel responsible." You know, people say that. I'm not interested in your motivation, I'm interested in whether you ever said those words.
A. I think I have. I -- I don't recollect it, but I think I -- I've -- I talked to -- to them immediately, said, "I'm sorry this happened, but there's no way of predicting what" -- "what will happen, but we just need to give it time, see what" -- "how much function he recovers."
Q. Okay.
MS. RINDEN: Marty, we've been going about an hour. Would now be a good time for a break?

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MR. DIAZ: Sure. Sure. Let me -- let me -- let me just double-check to make sure. I want to finish --
MS. RINDEN: Sure.
MR. DIAZ: -- what I've got here and then we'll take a break.
I'm looking at my notes and I think -- I think I've got it covered, so -- all right, thank you. Take a break.
MS. RINDEN: All right.
THE VIDEOGRAPHER: Off the record at 10:28 a.m.
(A brief recess was taken.)
THE VIDEOGRAPHER: Going back on the record. The time is 10:41 a.m.
Q. All right, Doctor. Here's where I want to pick up: After the surgery and after Mr. McGrew has a stroke, he comes back to see you I believe on November -- excuse me, October 3rd.
A. Yes.
Q. Let me see if I can find the note. There are two -- two documents that are in your records, Number 17 and Number 18. I believe one of them is your sort of review of a -- of an ultrasound that's done.

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A. Yes.
Q. Can you tell us what the -- what the ultrasound that was done in -- Was that done in your office or is that some -- done someplace else? Start there.
A. I don't know.
Q. Okay. In any event, what does this ultrasound show?
A. You're looking at Exhibit 17?
Q. Yes.
A. Okay. The impression is the right internal carotid is occluded, and there are no detectable Doppler signals in the artery.
Q. So what does that mean?
A. It means it's blocked, like you said earlier, like a highway's blocked.
Q. Okay.
A. So you can't see. You usually put the ultrasound probe and there's no signal, which meant there's nothing going through it. And then it's a large heterogeneous plaque in the left bifurcation and I see 50 to 79 percent. I was talking about the upper left side.
Q. All right. Let me stop you there and ask you, did you recommend surgery on the left carotid

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artery?
A. Did I?
Q. Yes.
A. No.
Q. Does that -- does that finding of a large plaque in the left internal carotid artery suggest you need to do surgery on that or not?
A. Not at -- You know, when they are not symptomatic because the 50 to 79, it's -- it's a wide range, so if you're considering surgery, you have to -- you do an angiogram or something.
Q. Okay. Then I want to just slide down a little bit. There's some initials there that I don't understand. Maybe you can explain them to me. It says "DVD1231" dash "5." What is that?
A. That's the -- All the images are recorded. You make a DVD of it.
Q. And is the MEP, is that the person who did the imaging?
A. Yes, the ultrasound technologist.
Q. Okay. And can you tell from that, those initials, whether that person worked for you or for somebody else?
A. Yes, she is -- That's -- Those initials stand

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for Mindy Parson. She's one of my techs.
Q. Thank you. Okay. And so then let's talk about 18. You then -- This is your note from the visit, and you say, "Patient's here for his first postop visit."
A. Yes.
Q. Okay. And you say -- A little further down you say, "Unfortunately, he suffered a stroke the next day," which you're talking about the day after the surgery.
A. Yes.
Q. All right. And apparently there was a feeding tube that had been placed for him to help him get food in.
A. Yes.
Q. Okay. And then you make reference to the -- the ultrasound that we just talked about.
A. Yes.
Q. And here you say that the left ICA is about 50 percent stenotic.
A. Yes.
Q. Does that mean that you actually looked at the ultrasound as well?
A. Images, yes.
Q. Okay.

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A. I do the interpretation and they send images.
Q. Does MEP, does that person also do -- give impressions and findings or -- or is it something that you do?
A. They do, the technologists. They give the impression, and then I read it if I agree with it.
Q. So 17, Exhibit 17, which is the ultrasound, the discussion of the ultrasound, those findings are from the tech, and then you read them yourself.
A. Yes.
Q. Okay. What if they come from outside of your office; in other words, somebody else does the -- the ultrasound study. Do you then review the ultrasound itself, or do you only look at the report?
A. I look at the report because I don't have access to it, and that's one of the problems with ultrasound that's done in different labs. The quality you don't know. The -- With carotid -- With vascular ultrasound actually, they -- it's -- it's technician dependent. Depend on who is doing it. If you know the technologist, you know the quality of their

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work and it's an accredited lab, then it carries more weight than if you don't know who did it.
Q. Okay. Now, I'm just going to show you Exhibit 22, and before I do that, let me -- if you look at Exhibit 18 at -- toward the bottom under Plan, it says, "We will add him in our recall list and follow him with carotid duplex ultrasound in three months for surveillance."
A. Yes.
Q. What does that mean?
A. We follow them to see how things are going, you know.
Q. Okay. I want to show you Exhibit 22, and apparently there must have been a scheduled visit for December 30th. Would that be consistent with this coming back to do an ultrasound in three months?
A. December -- This is scheduled visit for -- Sorry, I missed that question.
Q. Sure. If you look at the -- If you look in the document itself, in the middle of the document, there is a date of December 30th of 2014. Apparently Mr. McGrew didn't show up for a visit, and there was a fee charged by your

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office, a no show fee. Do you see that?
A. Yes, I see it, but --
Q. Does that --
A. -- I don't know anything about it.
Q. Does that tell us the date that he was supposed to come back then?
A. That would be my guess, but -- yes.
Q. Okay. And apparently then your office must have collected some amount of money on that no show fee because there's a payment of five dollars on there. Do you see that?
A. Yes, I see it.
Q. Okay. Now --
A. Do you want me to explain that or I don't get --
Q. If you have an explanation, sure.
A. For -- Yes. Because we -- It's typical for most labs when patients don't show up because a lot of patients will schedule and you have them on the schedule and they don't come and they didn't call to tell you to -- to reschedule, then you have that room that's not used and they just don't show up. So because of that, the vascular labs have introduced or instituted these fees. If you have an appointment and you

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don't call to notify us that you're not coming so we can use the room, there's going to be a fee.
Q. Okay. And that's what this was.
A. Yes.
Q. Okay. And this fee comes from your office, though; right?
A. Yes.
Q. I want to talk now about sort of the things that lead up to the decision to do surgery.
A. Okay.
Q. And in that I want to talk about that timeframe, so roughly the summer of 2014. We had talked earlier about what surgery you had done in the past, how many -- what percentage was this, what percentage was that. Can you tell us what percentage of your work, surgeries, was vascular, what was nonvascular thoracic, and what would still be considered cardiac that you were still doing in the summer of 2014.
A. Cardiac, zero. So I would say 75, 80 percent cardio -- sorry, vascular and then 20 percent -- 20 to 25 percent noncardiac thoracic.

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Q. Okay. So the name of your clinic is Northern Iowa Cardiovascular Thoracic Surgery.
A. Correct.
Q. Correct?
A. Correct.
Q. And what part is cardio, then, of your surgeries?
A. Cardiovascular. It's, you know, circulation, blood vessels, hearts, everywhere. That's what cardiovascular.
Q. Okay. So in terms of the -- When you talk about 75 to 80 percent of the vascular, it would be everything but open heart.
A. Yes.
Q. Okay. So let's talk about Mr. McGrew. He comes to you I believe it's August 18th of 2014. That's the first time you see him.
A. Correct.
Q. Okay. You will ultimately recommend surgery to him. Correct?
A. Correct.
Q. All right. So -- And I presume that you -- that the recommendation was let's do this open endo -- this open carotid artery plaque removal surgery with a patch.

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A. Yes. We talked about both open vessels, stenting, you know. I talked about both of them.
Q. Okay.
A. But -- but I recommended open in his circumstance, yes.
Q. And explain so we have it here in the record, what is it that said to you let's not do this endovascular technique?
A. For one thing, the CT angiogram showed the common carotid artery, the right common carotid artery was tortuous. It wasn't straight, and also in that report it was also mentioned that the plaque in the right internal carotid artery was mixed; in other words, calcified and soft plaque.
Based on those two things, I didn't consider it safe to put a stent because to get a stent through the tortuous common carotid in the first place, and then you put in a through -- A soft plaque -- a soft plaque is high risk because it's soft. It can break loose, and I didn't think it would be safe to be pushing a stent through that soft plaque to place the stent, so I thought it to be safest

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to just open it rather than -- because the risk of a stroke is slightly higher with a stent than open.
Q. Okay. All right. Now, I want to talk about that first visit.
A. Okay.
Q. The first time that an attorney for Mrs. -- for the McGrews asked for a set of records, there was no note produced for August 18th; in other words, your history and physical and your sort of assessment of it. After the lawsuit was filed, your office produced what is now marked as Exhibit 23, which is this document here, which I want you to identify for us. What is Exhibit 23?
A. This is the initial consultation.
Q. All right.
A. In my office.
Q. Do you have an explanation for why that wasn't produced the first time that records were asked?
MS. RINDEN: Well, hold on a second. I'm going to object to the form of that. First of all, I don't think it's been established that Dr. Otoadese was aware of that, and we're just

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taking your word for it, I guess, Marty, that it wasn't produced.
Subject to that, do you have an explanation or do you not know?
A. No, I'm surprised. I don't know why it would not be produced.
Q. Okay. I assume that these notes that you take are put into a computer of some kind?
A. Yes.
Q. All right. Has anything, and let's say in the last five years, anything changed with your computer system?
A. We did -- Yes, we did change -- When I left Cedar Valley, we had to get our own EMR, electronic medical, and -- and since then we have changed service, but it's just recently. Just within the last year or so we changed.
Q. So there's no -- If the records were created in 2014, when Mr. McGrew was there, there's no explanation that they would have been lost in some way --
A. No, no.
Q. -- for example. They should have all been there, correct?
A. Yes, they should have.

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Q. Okay.
A. The first time I'm hearing this. I -- There's no reason why they shouldn't produce it.
Q. Okay. So let's talk about Exhibit 23. You indicate on here -- and by the way, do you -- how do you do these -- these notes? Is this something -- Do you dictate or do you type them yourself or how does that work?
A. I dictate and the secretary types it.
Q. Okay. So under Chief Complaint, it says, "Patient complains of carotid stenosis." Do you see that?
A. Where? Yes, I see that. Yeah.
Q. Do you really believe the patient came in and said, "I'm complaining here of carotid stenosis"?
A. No, I didn't -- No.
Q. Okay.
A. And I -- I didn't dictate that.
Q. Okay. So who would have dictated it, then, if you didn't dictate it?
A. We have a form that's filled out by the nurse. The patient comes into the office. The patient fills out a form. Before I even see the patient, the nurse takes them in, weighs them,

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gets their vitals, fill in most of what you see there, the medications and the other things. They fill them in, and then I come and I see the patient, and then I dictate and they fill in what I dictated. So a lot of those were filled in before I even saw the patient.
Q. Yeah, so --
A. So I think that chief complaint was the person who filled that out wrote that.
Q. Okay. I'm trying not to step on your next question. So what part of Exhibit 23 comes from your dictation?
A. The -- Says, "Patient is here for" --
Q. So the history part.
A. -- the first part, and then the impression and plan.
Q. All right. So I want to focus with you on those areas, if I can. In terms of the history, it says, "The patient has no previous history of strokes or carotid artery disease." Correct?
A. Yes. Correct.
Q. What would be history of carotid artery disease? What kinds of things would tell you that they -- that that's part of their history?

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A. If they tell you. They will tell you, you know, that "I had a stroke before" or "I had" -- yes.
Q. Okay. It says, "He relates that he had an episode of transient loss of vision in the right eye several days ago." Correct?
A. Yes.
Q. Okay. Did the patient use "transient" or is this your interpretation of what the patient shared?
A. That's my interpretation.
Q. All right. Then it says, "The episode lasted about a minute and has not recurred."
A. Correct.
Q. Okay. It's -- I'm going to read all the way through, and then we're going to talk about all this.
A. Okay.
Q. "As part of the workup, a carotid duplex ultrasound was performed at an outside facility. The study showed 50 percent stenosis of the bilateral ICAs and critical stenosis of the bilateral ECAs. Patient is now referred to our clinic for further evaluation and management."

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I read that correctly?
A. Correct.
Q. And who had referred this patient to you?
A. It's -- it's up there. See the referring physician and provider? See up there? John Musgrave, M.D.
Q. All right. So Dr. Musgrave apparently refers this patient for you to look at. Correct?
A. According to this record, yes. It's probably Musgrave or Mauer, I'm not sure.
Q. So let's talk about this transient loss of vision. What's the significance of that?
A. It's -- That's the medical language for it. It's called amaurosis fugax. The -- the most common cause in -- in this age group will be carotid disease.
Q. Okay. Let's talk about Exhibit 5, which I'm going to hand you here. This is the -- the ultrasound that was the outside facility ultrasound that's been referenced in your note, and is it correct to say that this ultrasound was done on August 6th of 2014?
A. Yes.
Q. And it's done at United Medical Park in Waterloo. That I assume has got nothing to do

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with your clinic. Is that correct?
A. That's correct.
Q. So this is one of these situations you talked about earlier where you don't actually get to see the ultrasound itself.
A. Correct.
Q. You only get to look at their report.
A. Correct.
Q. Is it worthwhile to look at the ultrasound itself?
A. No, it -- no.
Q. So, for example, if you were interested and you wanted to go look at the actual ultrasound that was done, is that something you could do?
A. It's not something I think has been official because as I said earlier, the ultrasound you interpret depends on the technologist, so it does not matter. If the technologist is somebody you know and you believe their work, then you can take a look at it. But when it comes from an outside facility, the technologists, they have the probe. They are looking and they are recording pictures they want to record. So how accurate the study is depends on the technologist, and so I would not

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look at it.
Q. Okay. I understand. So, however, you had your own lab at this point or not?
A. Yes, I ---
Q. Okay. And could you do an ultrasound in your lab?
A. If I wanted to, yes.
Q. Okay.
A. But the problem with that --
Q. Is?
A. -- is reimbursement. When somebody has had an ultrasound that soon and you try to do another study, you don't -- you don't get reimbursed for it.
Q. Okay.
A. Because the government says it's a waste of time. He just had an ultrasound and we're not going to pay for another ultrasound. The insurance companies don't pay.
Q. Gotcha. Okay. So is that the reason why it wasn't done in Mr. McGrew's case?
A. No. I was going to -- I was going to do a CTA anyway, so did not matter.
Q. Okay. All right. So let's look at this ultrasound that was done, and let's assume for

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the sake of our discussion that the -- that the values that are found here, the numbers that are on here, are correct. And by the way, do you have any reason to doubt that an ultrasound done at United Medical Park by Rajeev Anugu, A N U G U -- I'm not sure if I'm pronouncing that name correctly. Do you have any reason to believe that that ultrasound is not a valid, properly done ultrasound?
MS. RINDEN: Object to the form. Go ahead.
A. Dr. Anugu did not do the ultrasound. He's interpreting it.
Q. Okay.
A. It does not say who the technologist was who did it.
Q. Okay.
A. And so I -- I -- I don't -- I've seen so many poor-quality ultrasounds done that I don't even know that it's an accredited lab.
Q. I understand. So Dr. Anugu? Am I pronouncing it right? Do you know him?
A. Yes, I do.
Q. Is it a he or a she?
A. A he.

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Q. Okay. And is -- is he qualified to read and interpret ultrasounds?
A. I don't know that. He's a radiologist, but -- he's a radiologist. He's Dr. Halloran's partner.
Q. Okay. So I guess what I'm asking is if Dr. Anugu thought that the quality of the ultrasound that was done on this patient was not up to proper quality, what are his options? What can he do?
A. I don't -- I can't second-guess him, but I can tell you, too, that if you read his report --
Q. Yeah.
A. -- toward the end he recommended -- he said, "If clinically appropriate, CT angiogram of the neck can be considered."
Q. I understand that.
A. Okay. That tells me that he's not too sure about it, so if you're really -- if you want to pursue it, get a CT angiogram.
Q. Okay. So I guess my question, then, is based on what you just said, is it your contention that you put no weight on this ultrasound, that you put everything on the CTA?
MS. RINDEN: Object to the form.

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Argumentative.
You can answer.
A. This particular ultrasound, yes, I don't put any weight on it.
Q. Okay. All right. But let's say you did, okay? I'm going to do a hypothetical. Let's say you found that the -- that the ultrasound itself is -- created these values that are seen here. Do these -- What do these values indicate in terms of -- well, the amount of stenosis or narrowing found on the right side of the internal carotid artery?
A. I don't know. I don't -- I don't know how the values were -- were generated. I have no idea. I don't know where they came from. I don't know how they were generated so I can't interpret it.
Q. Well --
A. Just looking at those numbers.
Q. Yeah, I'm just looking at the numbers and asking you, is that -- does that suggest that this is an individual who has severe stenosis?
MS. RINDEN: Are we still on the hypothetical that this question started with or --

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MR. DIAZ: Yep.
MS. RINDEN: Okay.
A. Well, just looking at the numbers on the right, I would not interpret that as 50 percent stenosis, no.
Q. What would you interpret it as?
A. It's no significant disease. No disease, actually.
Q. Right. In fact, if I understand correctly, there is a -- there's a -- I don't know what they call it, a society for ultrasound techs that put together sort of values and that I think everything that is peak systolic velocity, the PSV --
A. Okay.
Q. -- if it's less than a hundred twenty-five, it's considered essentially non -- not particularly significant.
A. Yes.
Q. Okay. And that's what happens here. There's -- there's nothing to suggest there is disease on here. Correct?
A. Yeah, if -- based on that, you look at those numbers, yes. None of it in the -- except for the left external carotid. That's one-seventy.

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Q. And you didn't do surgery on the left external carotid.
A. No.
Q. Okay. Now, the other thing on the ultrasound report, it says the reason for the exam is amaurosis fugax?
A. Yes.
Q. All right. I want to try to understand this concept. What causes amaurosis fugax?
A. Various causes. It could be circulatory -- circulation, like carotid stenosis, emboli from the heart, emboli from the carotid arteries, ophthalmic atherostenosis. That's circulatory. It could be intrinsic eye problem; for example, a tumor or, you know, iris disease or even dry eyes. And it could be neurologic problem: Multiple sclerosis, lupus, migraine headaches. So there are three -- three main categories.
Q. Okay. So for purposes of determining whether or not this individual has carotid artery disease, it is a factor. The fact that this patient's telling you, "I've had this transient loss of vision," right? And I think -- Did he tell you it was in one eye --
A. One eye.

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Q. -- both eyes?
A. One eye, the right eye.
Q. Okay. All right. So I know that in the -- in the decision-making process to decide whether somebody is a candidate for endarterectomy that one of the things to look at is whether the person is symptomatic.
A. Yes.
Q. Okay. Is the -- is the fact that he describes this to you, does that make this patient symptomatic?
A. Well, there are other factors you take into consideration. The -- which I mentioned earlier. For his age -- in his age range is overwhelming. There's overwhelming evidence that amaurosis fugax in somebody his age is caused by carotid disease.
Q. Okay.
A. So he had risk factors also; hypertension, for example. That increases the risk too. So carotid disease, it's -- it's number one when it comes -- when you're evaluating a patient who is 69 years old and amaurosis fugax, yes.
Q. Okay. So I'm not sure if you answered my question or if I heard it correctly, so I'm

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going to ask it just to make sure. Does that mean this patient is symptomatic?
A. Yes.
Q. Okay. So symptomatic patient, and then the next part of the equation is do they have -- do they have stenosis really. You need to know that, right?
A. Yes.
Q. Okay. And you've got -- At this point as you're meeting with this patient, you have an outside ultrasound that suggests he doesn't have carotid artery disease or if he does, it's not -- at least it's not severe. Correct?
A. Correct.
Q. But you're -- For the reasons you've told us, you're not sure you want to rely on that.
A. Correct.
Q. In fact, you're more than not sure. You don't want to rely on that. Correct?
A. No, not correct, but -- but I was not going to rely on it completely, yes.
Q. Okay. So you want a CTA. Correct?
A. Correct.
Q. And so that's -- What is a CTA exactly?
A. A CT angiogram.

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Q. Are you qualified to read CTAs?
A. No. Not officially, no.
Q. Okay. What does that mean, not officially?
A. Since I don't have a certificate to read them.
Q. Okay. But does that mean that you don't read them?
A. I can read them. I can tell gross -- gross things, yes.
Q. So, for example, in Mr. McGrew's case, did you actually read the CT angiogram that was done after you ordered it?
A. Yes, I did.
Q. You looked at it.
A. Like -- Yeah, like a surgeon you look at it. Oh, yeah, this is -- this is critical, but I'm not a radiologist.
Q. I understand that. Okay. So do you then order the CT angiogram?
A. Yes.
Q. All right. And do you tell the patient where they should go for the CT angiogram?
A. No.
Q. In other words, do you point them in the right direction?
A. No.

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Q. All right. Did you tell them --
A. My secretary does that.
Q. Okay. And do you have a list of -- of places where they can go?
A. They can go wherever they want.
Q. Okay. And did you recommend that they go to see Dr. Cammoun?
A. Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes.
Q. Okay. What's alternative to -- What is ADI, by the way?
A. Advanced Diagnostic Imaging.
Q. Okay. And where is that located?
A. In Waterloo on San Marnan.
Q. And where else can you go if you -- if you don't want to send somebody to ADI? Where are the alternatives?
A. Allen Hospital, Covenant Hospital, Sartori Hospital. Wherever they do angiograms.
Q. Well, you had 99 percent of your surgeries at Allen Hospital.
A. Yes.
Q. Correct?
A. Correct.
Q. When you refer patients -- When your staff refers patients, for that matter, do you tell them to go to Sartori or Covenant?

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A. It depends on where the patient lives and, you know, we give them the option.
Q. Yeah.
A. Yes.
Q. But would you agree that most patients generally don't know where to go or that you sort of point me in the right direction?
A. That's true, yes.
Q. Okay. All right. So if you tell them to go see any particular radiologist, you're going to say, "I want you to go" -- "I would prefer you go to ADI."
A. Yes. I -- I do have that preference, yes.
Q. And is that preference -- What's that preference based on?
A. Ninety-nine percent of the time, if you order a study like a CTA at Allen Hospital, even Covenant, but I think more Allen, it's sent out to Visual Radiology, which is -- Visual Radiology, which is not even in state. I think it's somebody in St. Paul or somewhere. Sometimes it even goes abroad, and -- and it's read somewhere and then they -- they result --

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they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away.
Q. Okay. All right.
A. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it.
Q. All right. And that's what happened here, Mr. McGrew went to ADI?
A. That's what happened. It happens to all of my patients.
Q. Okay. So he goes off to ADI, gets that test done. When -- when do you get the results? That same day or is it the next day or what is the -- what's --
A. Most of the time the same day -- the same day it's done, within minutes or hours.
Q. Okay. Let me find the CT angiogram. So I have that here now. This is Exhibit 6. This is the -- this is a copy of it.

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A. Okay.
Q. So let's say the report comes back. Do you get -- Do you first talk with Dr. Cammoun or do you see the report or does it matter?
A. It varies. There have -- there have been times when, you know, they don't have the report ready but they'll call me and say, "I just did this CT angiogram and, you know, I have not dictated the report yet, but I understand you want the report right away," and he taps me. There are other times when the patient -- the report is sent so I -- I see the report. So it varies.
Q. All right. And I imagine there are situations where if there's something specifically bad on the report that it's the kind of thing you need to let somebody know right away.
A. Yes.
Q. Okay.
A. And -- and he does that.
Q. Did -- Do you recall in Mr. McGrew's case what happened, whether he ever -- Did he ever speak with Dr. Cammoun about this?
A. I don't recall.
Q. All right. So can you say one way or the other

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whether you relied solely on his report or on conversations with him or you -- you chose not to rely on him at all? Can you tell us anything about that?
A. On him, him who? Him who?
Q. Dr. Cammoun.
A. Oh. No. I rely on the history I took from the patient, the CT angiogram.
Q. Okay.
A. Right, to make the decision.
Q. Now, when you get the report, are you -- do you know what you're looking at when you actually see the report? In other words, there are -- there are -- Let's find 6, for example. There are statements along the bottom of that first page, numbers; for example 1.9, 8.8, 5.2, 7.9. Do you see those numbers?
A. Yes, I see them.
Q. Do you know what those mean?
A. Yes, of course.
Q. Okay. That's what I'm -- that's what I'm trying to understand. I don't mean to -- I'm not trying to --
A. No, it's okay.
Q. -- make you think that you don't understand. I

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just want to know what you -- how you can look at these.
A. Okay.
Q. What is the significance of these numbers?
A. He -- he -- he -- he's trying to tell us how he came up with the degree of stenosis.
Q. Okay.
A. Based on these measurements.
Q. So if you were in school back in the days when you took math class and the doctor -- and the teacher told you to show your work, you might come up with the answer, but then if you have to show your work, you have to explain how you arrived at that?
A. Yes.
Q. Is that the idea here?
A. Yes.
Q. Okay. So Dr. Cammoun makes a statement. He says, "This leads to approximately 65 percent luminal stenosis compared with the distal vessel," in parentheses, "postbulbar ICA." What does that mean?
A. It's hard to tell without -- Okay, the -- the first thing there says, "Calcified and noncalcified plaque" --

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Q. Okay.
A. -- "identified leading to a luminal stenosis at the proximal ICA bulb, diameter 1.9 millimeter."
Q. Okay.
A. That means he had measured the opening, there's a plaque, and the -- the lumen is narrowed from this to that (indicating). So he measures the opening.
Q. And what's what the 1.9 means.
A. That's what the 1.9.
Q. That's the opening.
A. Yes, that's the opening.
Q. All right.
A. Then he says the length of the narrowing is approximately 8 millimeters, so he measures how long it is. Then he says the normal diameter of the postbulbar ICA is approximately 5.2, so you now go past where the stenosis is and you get a measurement there, supposedly the normal patent internal carotid, so that's 5.2. Then it goes down to the distal common carotid. The carotid artery starts as one common carotid and it divides into two. So the common, before it divides, it measures 7.9.

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Q. Okay. So here's, I think, what we should do. We've got a piece of paper here.
A. Okay.
Q. I've got a couple of pens, two different colors. What I'd like you to do is diagram the common carotid artery and the bifurcation where it splits off into these two, and then if you can, based either on your recollection of what you saw on the CT angiogram or what Dr. Cammoun has put in here or whatever combination, show us the location, and I'm not going to hold you to the -- you know, to scale. I just want to get an idea of where the plaque and this noncalcified plaque was.
A. Okay.
Q. And then we can also use it to help us understand the location of each of these measurements.
A. Okay.
Q. Fair enough? We're just going to be quiet. You don't -- It would be better if you just diagramed it first, then talk about it later.
A. Okay. This will be ICA, ECA, CCA.
MS. RINDEN: Don't talk. She has to record it.

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THE WITNESS: Oh, sorry.
Q. Then using the red pen, why don't you use the plaque -- show us where the plaque was.
A. Approximately.
Q. Okay. Now, before you leave that and before we mark it, I'd like to take the blue pen --
A. I'm sorry.
Q. -- and like all good artists, you need to sign, so if you could put -- sign it.
A. I'll just put "Tony."
MR. DIAZ: Thank you. All right. We'll still be off the record.
(An off-the-record discussion was held.)
(Deposition Exhibit Number 24 was marked for identification by the reporter.)
Q. All right, Doctor, now we've marked this as Exhibit 24.
A. Okay.
Q. And all I want you to do at this point is confirm that this is the diagram that you prepared while we were partly off the record.
A. It is.
Q. Okay. And I think what you have done is you have -- and let's make it clear. First of all, you have diagramed this area of what people

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call a bifurcation, where it splits off.
A. Yes.
Q. Okay. You have named each of the -- these sections --
A. Yes.
Q. -- correct? Then you have with a red pen put a -- sort of squiggly lines where you have marked the location of the plaque. Correct?
A. This one, yes (indicating).
Q. And then in between you -- in very small writing you put 1.9, which would be -- matches with what Dr. Cammoun puts in his CTA report.
A. As the opening, yes.
Q. Correct. And then the 5.2 is above that, that's the diameter of the --
A. Normal internal carotid artery.
Q. The place where there isn't plaque.
A. Yes.
Q. Okay. And then below that, it's -- the 7.9 is the -- is the common carotid artery. That's the diameter there.
A. Yes.
Q. So is the location of the plaque just in this one -- these two areas that you have here?
A. Yes. It's just there (indicating).

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Q. One on each side of the ICA as --
A. No, it's -- it's circum -- it's circumferential. This is through the diagram, so it's circumferential.
Q. So it's just -- It's a ball almost.
A. Yeah, it goes around (indicating).
Q. And it's got some length to it, I assume; right?
A. These numbers, by the way, these are millimeters.
Q. Right.
A. It's -- it's important that we put the -- it's important -- it's important that I put that there. That -- that's -- We're talking millimeters, not centimeters.
Q. Yeah, because I was going to ask you about that. Dr. Halloran's outside film, he has centimeters on there.
A. Yeah, that's why I put it in there so --
Q. Yeah, is that -- in your estimation, is that a typo or is that an outright mistake or what is it?
A. Well, you have to talk to him. I saw that, and I thought that's interesting because he -- if he's saying they're centimeters, then we're

dealing with a whole different and we're dealing with an aneurysm because the -- the common carotid that big is an aneurysm.
Q. Right.
A. But -- but then right below that he -- he interpreted the left internal carotid in millimeters, so it's hard to say. Did he mean centimeters, which changes the whole story because then we are talking about aneurysm. So I don't know. He will have to tell you.
Q. Sure. I understand. But -- but what we're really talking about is millimeters in this area, right?
A. Yeah. But it's important because if it is centimeters -- If you said the -- the carotid artery's this instead of that (indicating), those numbers become important because in the interpretation, Cammoun has the opening as 1.9 millimeters. Halloran has 3.2 centimeters.
Q. Sure.
A. So is he looking at this artery like this?
Q. Yeah, we're talking at that -- at that point we'd be apples and oranges.
A. Yes.
Q. Agreed? Yeah, I understand. So in terms of

these numbers, do you then do something with these numbers?
A. Yeah. That's how I came up with -- with his numbers. There are -- there are three different ways you can use these numbers.
Q. Okay. Let's go through each of them then.
A. One of them is -- is the so-called NASCET. NASCET, N A S C E T. That stands for North American Symptomatic Carotid Endarterectomy Trial. The measurements -- No, I'll just use this.
MS. RINDEN: Pen?
A. This one. If you use the NASCET criteria, it says to determine the -- the stenosis, you have to -- you take the 5.2 minus 1.9 divided by 5.2 times 100.
Q. Okay.
A. Okay. The European Carotid Surgery Trial, it's called the EC -- ECST, they don't use that. They do it differently. They take the 1.9, divided by the size of the bulb, which is the -- they estimate where the actual lumen starts, where the -- like the edge, this edge here. They use that instead of using what's inside. They -- they estimate where the

natch -- the -- the wall actually is. For example, the true wall is like this (indicating). So they take this number from here to there. They -- So this would be this number here minus 1.9 divided by that number.
Q. So the formula is the same, it's just a different number that you're choosing for your denominator, so to speak.
A. Yes.
Q. Okay.
A. And then there's the -- the common carotid matter, which takes -- that takes 7.9 minus 1.9 divided by 7.9, and that's important because depending on where you are, the degree of stenosis or what equation you're using is going to be different. The NASCET -- sorry, the -- the European one, the ECST, overestimates the stenosis.
For example, a NASCET stenosis of 30 percent is the same as ECST stenosis of 65 percent. So 40 percent NASCET is 70 percent ECST, you know. So when it gets to higher stenosis, like at 90 percent, then they come closer because NASCET of 90 percent is the same as ECST of 97 percent, so when you get there,

it's closer there, I guess to be more accurate. So it all depends.
Q. And what -- what does it look like to you that Dr. Cammoun used in his report?
A. They both used the same. I looked at both and they used the NASCET.
Q. When you say "both," meaning --
A. Cammoun and Halloran.
Q. Thank you.
A. The difference is the -- the diameter they got. While Halloran says the open lumen where it's the most stenotic is 3.2 and Cammoun says it's 1.9.
Q. Okay.
A. So those are the kind of things that --
Q. So when it comes to then you getting this report --
A. Yeah.
Q. -- do you rely exclusively on Dr. Cammoun's findings or do you then look at them -- at the CTA yourself and come up with your own assessment?
A. I put everything together.
Q. Okay.
A. From the history I obtained, it's a classic

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amaurosis fugax and it's symptomatic. And from the CTA, it is -- he says it's 65 percent, Cammoun. This was before Halloran even got involved.

Q. Right.

A. So, yes, the CTA helps me with my decision-making because if Cammoun's reading comes back and it says it's 20 percent or 30 percent, it will make me think more -- think twice before I take patient to surgery.

Q. Sure. And then if -- I had a question, it just kind of went (indicating audibly).

A. It will come again.

Q. It's okay. Let me think back because I think I'll get it back here. Well, maybe I won't get it back, we'll see.

Now, in terms of your review, so when you're looking at the CTA, do you do your own measurements as well? In other words, do you come up with your own work, or do you only come up with a final number?

A. No, I don't do measurements.

Q. Okay.

A. I'm a surgeon. I look at it, I say, "Oh, that's" -- "that's at least 70 percent. Look

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at that thing. It's irregular and it's got a big chunk of calcium there and it's at least 70 percent, but we'll wait and see what the radiologists say," because the radiologists have special -- special instruments they use. It's on a computer-based, so they get better measurement than I can get just looking at it.

Q. Okay. So let's say you now have 65 percent from Dr. Cammoun's report. You in your, I think, notes thought it was 70 percent. Why did -- Where did you come up with 70 percent?

A. From what I just said. I look at it, I say, "Oh, this is 70 percent." I'm eyeballing it.

Q. Just the eyeball test.

A. Yeah.

Q. Okay. And who -- who recognizes the eyeball test as the method of -- of just determining surgery for --

MS. RINDEN: Hold on.

Q. -- this condition?

MS. RINDEN: Hold on a second. I'm going to object to the form. It's argumentative.

You can answer if you understand the question.

A. Yeah. Yeah. Nobody. That's why I rely on the

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radiologist's final report. I am just looking at it and saying this is 70 percent, but I'm not going to act on that 70 percent if the radiologist's report doesn't agree.

Q. Well, the radiologist says it's 65 percent. Is that a significant difference?

A. Not in my book.

Q. Okay. What -- what is the sort of recognized -- For a symptomatic patient, what's the recognized percentage of stenosis necessary to justify surgery where the surgery will have greater success than the risk associated with that surgery?

MS. RINDEN: I'm going to object to the form. Vague as to "recognized." Recognized by who?

MR. DIAZ: That's why I'm asking him.

MS. RINDEN: You can -- Well, I don't think the question defines it. I think it's vague. That's my objection.

You can answer if you can.

MR. WEILEIN: I'm going to join in the objection. It's not clear, recommendation by radiologist, by vascular surgeons, or who.

MS. RINDEN: Right.

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MR. DIAZ: All right, let me withdraw that and ask it.

Q. Doctor, do you -- do you look at -- do you rely upon any particular recommendations, guidelines, anything you want to use from the literature or from research that you've done to guide you in terms of deciding "I'm going to do surgery at 65 percent," "at 70 percent," at some other figure?

A. The guidelines is 50 percent for symptomatic patients.

Q. Fifty percent, okay. And the guidelines that you're using are what? Which ones?

A. All the guidelines. The Society of Vascular Surgery guidelines, any guidelines you want to look at. Fifty percent are symptomatic.

Q. All right. Symptomatic -- But it has to be symptomatic.

A. Fifty percent.

Q. All right. All right. Okay. Now, so if you relied solely on -- let's say you did -- this is hypothetical. If you relied solely on Dr. Cammoun being correct that it's 65 percent, that in your estimation is sufficient to perform surgery on this patient, this

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symptomatic patient.
A. Yes.
Q. Okay. Now, what if he's not symptomatic? What if you have an asymptomatic? Do the numbers change or is it essentially the same?
A. Sixty percent for asymptomatic.
Q. Okay. So now, at 65 percent -- I'm going to use 65 percent because that's what Dr. Cammoun's got -- plus he's symptomatic, is surgery the only option for this patient?
A. Is the better option.
Q. So -- Which would suggest that there's other options. What are the other options?
A. Well, that's -- that's controversial. For the -- the -- the main controversy is with asymptomatic patients. With symptomatic patients, revascularization is pretty much the option; but with asymptomatic patient, yeah, you can make a case for best medical therapy; you know, statins, aggressive treatment of hypertension and other things for asymptomatic.
Q. All right.
A. But with symptomatic, no.
Q. When you met with the McGrews to discuss your recommendation, did you talk about alternative

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recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" -- "We could try statins and" -- "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family?
A. No.
Q. Your viewpoint is, "This is the only treatment option I'm going to offer."
A. He's symptomatic and -- Yeah, his carotid endarterectomy or stenting, those are the things that I discussed with them.
Q. All right.
A. But I -- I -- I discussed the fact that if he does not want surgery, it's okay, you know. But I didn't say "best medical therapy."
Q. Yeah. That was one of the things that you -- There was some mention made of that, what you just said. I'm going to find the reference to it. In one of your -- In answer to one of the discovery requests, it's a request for admission, you say -- this is request Number 12.
MS. RINDEN: Actually, hang on just a second. Let me get it.

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MR. DIAZ: Sure. Let me know when everybody's ready.
MS. RINDEN: You're in response to Request for Admission Number 12?
MR. DIAZ: Correct.
MS. RINDEN: All right.
Q. You say the following: You say, "While Dr. Otoadese believes his recommendation to Mr. McGrew would have been a factor in Mr. McGrew's decision to have the endarterectomy, the risks of not having surgery were also made known to Mr. McGrew."
A. That's correct.
Q. All right. So what other risks are you talking about? What are the -- what are the risks of not doing surgery?
A. Stroke.
Q. And that is -- Is that risk regardless of whether you do statins and other medications?
A. I don't know that. I did not discuss statin and other medications.
Q. I know. That's what I'm asking.
A. I wasn't comparing just statin and medication. Just risks of not doing surgery versus doing surgery.

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Q. Right.
A. Yes.
Q. So if you choose not to do -- So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do that."
A. Yes, that's an option.
Q. And you say to him, "Well, you understand if you don't do surgery, bad things can happen to you, which would include a stroke."
A. Yes.
Q. Okay. And the patient then says, "What kind of risk are we talking about? How likely is it going to be? When is it going to be?" that kind of a thing. What do you tell them?
A. Well, to put numbers on it, the risks of a stroke, fatal stroke -- fatal or nonfatal stroke is about 20 percent in two years.
Q. Okay.
A. For a symptomatic amaurosis fugax.
Q. Right. All right. But in this case when you would have told them this risk of 20 percent -- I mean -- I'm -- shouldn't be saying that. Did you ever say anything about 20 percent risk of

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not doing it?
A. I didn't say 20 percent but I said the risk of stroke is high.
Q. Sure. Did you -- Was that -- In your mind when you make that statement about 20 percent in two years, is that assuming that there is no treatment done on the patient?
A. Yeah, that's without surgery. Just continuing as --
Q. Yeah, it's different though. I'm not asking --
MS. RINDEN: Let him -- Hold on. You've got to let him finish. I want him to get his answer out.
Q. Go ahead.
A. Yes, because again, like I said earlier, I did not discuss best medical management because that's -- that becomes a factor in asymptomatic patients, so this is two different things.
Q. I understand. If -- if the patient -- if you -- if the patient says, "Doc, I don't want to do surgery. What can you offer me?" You would say, "I can offer you medical management, meaning medications, but you have to understand there's risk associated with just doing that." Correct?

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A. Yes.
Q. And if you do that, if you do medical management, does the risk, that 20 percent, does that change in some way? Does it go down to 10 percent or 5 percent or does it just stay at 20?
A. Nobody knows that for symptomatic patients, no.
Q. Do you assume that it will help some?
A. You could assume. It's no -- no -- Yeah, that's an assumption, but there are no studies that can support either way.
Q. Okay. All right. Now, patient now says to you, "All right, Doctor, you want me to do surgery. I'm going to go ahead and do it. When should we do it?" What do you tell them?
A. You know, sooner than later.
Q. All right. I mean, "Should I be back here tomorrow? Should I go home tonight?" What -- what's --
A. It's not emergent so we don't have to do it today, but we should do it sooner than later. It's not something -- I don't recommend putting it off with your symptoms because the risks of further problems is high.
Q. Right. So this 20 percent risk, that

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encompasses whatever time occurs between the time of decision that we should do surgery and the -- and the time of actually doing surgery. That's part of that risk. Right?
MS. RINDEN: Object. Vague.
You can answer if you can.
A. I don't know.
Q. Well, let me give an example -- Let me not give an example. Let's talk specifically here.
A. Okay.
Q. When did you recommend surgery to Mr. McGrew?
A. When he came for the second visit to review the CTA.
Q. All right. So that is when? All right. I'm looking at Exhibit 7. Now, Exhibit 7, this appears to be -- And this is confusing to me.
A. Okay.
Q. Okay? And so you have to help me here. There's a date that says "Office Visit," Date: August 28, 2014. Then below it there's a "DOS: 8-20-2014." Do you see that?
A. Yeah.
Q. Which -- which date is it?
A. The DOS is the date of service.
Q. All right. And this is where you talk about

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that you see that it's 70 percent stenosis.
A. Yes.
Q. And is that 70 percent based on your own --
A. Based on mine, yes.
Q. Okay. As opposed to you misstating, for example, that it was actually 65 percent on the report. Do you understand the difference?
A. I don't think that's a difference, in my view, between 65 and 70 percent.
Q. I understand. All I'm trying to figure out is when you put 70 percent in this document, are you -- is it that you thought it was 70 percent on the CTA, or is it your own assessment that "Regardless of what Dr. Cammoun says, I think it's 70 percent"?
A. Yeah, that's my own eyeballing it, say this -- this 70 percent stenosis, yes.
Q. Gotcha. Okay. "The patient has not reported recurrent symptoms since his last office visit last week."
A. That's true.
Q. Okay. So and then it says under Plan, "Based on his symptoms and the findings of the CTA, I recommend right ICA intervention," and then you apparently talk about doing the stent versus no

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stent.
A. Correct.
Q. Okay. And then you say, "In the end patient has elected the CEA." And then you talk to him about -- You describe to him the procedure and answered any questions that he might have.
A. Correct.
Q. Okay. So now on August 20th, here's what I want to know: If the patient says, "When?" when should you do the surgery?
A. Yeah, I sent them from there to go to my office -- my secretary and she'll schedule it.
Q. And what I'm asking you is during this time that you're waiting from -- from telling him that you should do surgery until the time that actually -- surgery is actually done, is this man at risk, then, under your assessment? Is he at risk for a stroke?
A. Yes. He's always at risk for stroke from symptomatic amaurosis fugax.
Q. Okay. All right. Now, Dr. Bekavac saw this patient a few weeks after the surgery and prepared a report. I believe, if I'm not mistaken, I provided you with a copy of that before the lawsuit was ever filed. Did you get

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a chance to see that?
A. Yes, I saw it.
Q. Okay. Have you seen it lately?
A. Yes.
Q. Okay. I'm happy to pull it out if you want to talk about it, but he has significant disagreement with you about, one, whether the CTA shows this 65 or 70 percent number. I think his -- I recall, and this is off the top of my head, something around 40 percent, something less than that --
A. Okay.
Q. -- maybe. And believes that the surgery was unnecessary. Obviously you disagree because you made a recommendation for surgery. So tell me what's wrong with Dr. Bekavac's assessment.
A. I don't know how he came to that conclusion, so I can't tell you, but I disagree with it because it's not 40 percent stenosis.
Q. Have you ever sat down and talked to him or called him on the phone and said, "What are you doing putting this in writing?" or anything like that?
A. We're not supposed to discuss these things. I've never discussed it with anybody, not even

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Cammoun.
Q. So let's talk about Dr. Halloran's review.
A. Okay.
Q. Do -- do you think Dr. Halloran is qualified to comment on the CTA?
A. Yes. I -- John's a good radiologist, yes.
Q. Okay. Now, obviously we've noticed this centimeters/millimeters thing. Let's assume we're talking about apples and apples and not apples and oranges.
A. Okay.
Q. He comes up with a different essentially opening, as you described it, an area where blood can still pass through, so that opening is bigger. If that is correct, then would you agree that the number cannot be 65 or 70 percent?
A. Again, you're asking me to speculate, you know. I don't -- I -- I disagree that it's 32 percent from his calculation. Strongly disagree.
Q. Have you gone back since -- Since you did the recommendation and eyeballed it, have you gone back to look at the CTA?
A. Multiple times.

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Q. And do you think that -- Does that -- does that change your viewpoint at all?
A. Not at all.
Q. All right. And do you -- I know you don't do this as part of your assessment, but have you gone to look at the measurement technique that's available on this -- on this?
A. I've played with the image, turn it around, look at it, see if there's any way, you know, I can come up with anything that lower. No.
Q. Okay.
A. It -- The problem with -- You know, I don't know how much of all this I should be saying, but with imaging, you know, carotid endo -- carotid surgery is probably most common surgery that vascular surgeons do. We've been doing them since the '50s, and it's probably the most studied procedure. But after all these years, there's still no agreement. There's no agreement on the best -- how to decide what the preop imaging -- what's the best way of imaging. There's no agreement on that.

There are -- there are -- there are studies that say CTA underestimates stenosis and MRA overestimates stenosis. There are

groups that even would do surgery just with -- without imaging -- without CT or MRA, just with ultrasound. So there's no -- there's no agreement on that. There's no agreement on the criteria for interpreting the imaging studies even when you decide what imaging studies.

You can have five radiologists in this room and give them the same image. They'll come up with different numbers, guaranteed. True for surgeons too. And there's also no agreement on how you select whose patient to offer surgery to either. So it's -- it's controversial. It's -- and it's -- it's going to be like that. I have examples that I can show you of patients just like Mr. McGrew who have had four radiology -- three radiologists and including Halloran and Bekavac who have given different -- completely different interpretations.

Q. And --

A. In the end I made the decision what to do with him.

Q. Are you aware of -- of surgeons that would take a patient like Mr. McGrew, symptomatic -- in your view symptomatic and 65 percent, for

example, and say, "Not yet. We're going to wait to see if it gets to 70 percent or more." And are you aware of people that will do that?

A. No. Not for symptomatic patients, no.

Q. All right.

A. Asymptomatic, yes.

Q. Okay. Did you share this -- this discussion you just had with us about -- that's controversial and that different people look at different things, did you discuss that at all with the patient and say, "Hey, you know, you might want to get a second opinion. Let's get two people on this"?

A. Not with Mr. McGrew, I don't recollect, but I do that quite frequently with -- with patients. I'd say, "You don't have to have your surgery here. You can look at a second opinion, you know. As a surgeon, this is what I think, but you don't have to do this. You don't have to do it here." I do that. I don't remember if I did that with him.

Q. All right.

A. But I do.

MR. DIAZ: Okay. Let's -- let's take a break. I'm almost -- I think I'm almost done.

MS. RINDEN: Okay.

MR. DIAZ: So I want to just check.

THE VIDEOGRAPHER: Going off the record. The time is 11:57 a.m.

(A brief recess was taken.)

THE VIDEOGRAPHER: We're on the record at 12:12 p.m.

Q. All right. Doctor, I have a few more questions about Exhibit 6.

A. Okay.

Q. Let's assume -- It's a hypothetical. Let's assume that Dr. Cammoun, instead of putting down "leads to approximately 65 percent stenosis" says, "35, 40 percent stenosis." And you get the CTA. Are you going to look at the CTA when he says, "35 to 40 percent"?

A. Yes. Of course I look at it.

Q. Okay. So now you look at it and you eyeball it and you think, "This is 70 percent. What's he talking about 35 or 40 percent?" What do you do in that instance?

A. That has happened a lot and I pick up the phone, I call him, and I say, "Are we looking at the same thing because I'm seeing 60" -- "I'm seeing at least 70 percent here. That

thing is ugly," you know. And he would say typically, "I'm looking at it, too, and however I look at it, I can't get more than 30 percent. Well, tell me what you're looking at is probably because of the plaque. You got a heavy plaque there, but I really don't see anything more than 30 percent."

That's the kind of conversation we have, you know, and -- and I'm obviously content with it because he said, "I" -- "I've rotated it, I've looked at it. No, it's not more than that." I say, "All right." That's it.

But I've also seen the -- the opposite where even Cammoun and Halloran and Bekavac, they -- they've made mistakes too. You know, I've had -- I just had a case where it was a leg thing, you know. Patient is complaining of left leg pain. You know, left leg is what is bothering him all the time.

We did a CT angiogram and Cammoun read it, and he sent it back and it's normal. The vascularization on the left is completely normal, and the right had some disease in there. But I put up the picture and I could see right there that the external iliac artery

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is -- you know, by my eyeball is at least 80 percent.

I picked up the phone, I called him and said, "You know, why don't you take a look at it again because I have" -- "this is what I'm looking at and I see there's a stenosis there, the origin of the left external iliac artery." And he put it up. He says, "You know, you're right." You know. "I'll send an addendum."

So he corrected it. It was, you know, 75 percent stenosis and, you know, I can have that conversation with him and that's how we work, and I couldn't have that with somebody at Visual Radiology in another country or something. So, yes, it's ---

Q. Okay. But I get from your answer that you're ultimately -- it sounds like you're ultimately relying upon what the radiologist is telling you as to what he or she sees with regard to percentages.

MR. WEILEIN: Objection. That's a misstatement of his testimony.

A. Yes. Combined with the history, everything put together, yes.

Q. Okay.

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A. I have -- I -- I have -- I've seen cases where the neurologists or radiologists estimate a stenosis that's critical, and I did not operate because from the history that the patient gives, putting things together in spite of them calling it 80 percent, I did not operate. I said, "You know, I just don't think they're symptomatic from this."

Q. All right.

A. So --

Q. Second thing I want to ask you about, you made mention earlier about guidelines that you rely on for symptomatic patients who have more than 50 percent stenosis as being surgical candidates. Can you provide us with two or three documents that you --

A. We can look them up. Sorry, I am speaking too soon. It is the Society of Vascular Surgery. You can Google it, I mean.

Q. Okay.

A. Yes, the Society of Vascular Surgery guideline.

Q. Okay. Anybody -- Any other guidelines that you're relying on for your statement that you can do surgery with a symptomatic patient where stenosis is 50 percent or greater?

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A. That's -- that's known. Anybody who does this work will tell you that. Yes.

Q. Okay. Were you aware -- Remember when I sent you a letter right at the beginning, and I provided you with a copy of what might be a lawsuit and said, "Let me know if" -- you know, "You talk me out of this," essentially. I have a copy of it here somewhere if you want me to show it to you. Do you -- Because I asked you about that earlier, do you remember?

A. I remember a letter. I've -- I've got --

MS. RINDEN: Hold --

Q. Let me make it easier. Let me find it.

MS. RINDEN: Well, hold on a minute. So now you're wanting to ask him about a settlement demand you made threatening a lawsuit if he didn't --

MR. DIAZ: No.

MS. RINDEN: -- either provide you with some reason that you're wrong or give you some money. Is that what we're talking about here?

MR. DIAZ: No. Not a settlement demand.

Q. Here's the -- here's the letter itself here.

MS. RINDEN: Hold on.

MR. DIAZ: You get a copy.

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MS. RINDEN: Hang on, Tony. I want to look at it first.

Well, you can read it and then we'll let him ask his question, make an objection to it.

A. Yes, I remember it.

Q. Okay. And I think you indicated that you did not respond to that. Correct?

A. I referred it to my attorney.

MS. RINDEN: And we're not going to talk about anything that we've discussed. Attorney-client privilege, so --

MR. DIAZ: Yeah, I'm not -- and I'm not asking about ---

Q. I guess here's my question to you: Were you aware that I did the same with Dr. Cammoun? That I sent him exactly the same letter?

A. No.

Q. Were you aware that Dr. Cammoun's lawyer responded? Were you aware of that? Have you ever seen that letter?

MS. RINDEN: Hold on a second.

A. No.

MS. RINDEN: We can -- I don't have that with me. We've talked about the articles that Dr. Cammoun provided in this lawsuit through

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George.
THE WITNESS: Yeah.
MS. RINDEN: That's what he's talking about.
THE WITNESS: Okay.
MS. RINDEN: So you have seen that, Tony.
THE WITNESS: Okay.
Q. All right. Well, you're aware that Dr. Cammoun's provided -- at least through his lawyer provided articles --
A. Okay.
Q. -- in which the claim is that before you do surgery on this patient, on Mr. McGrew, that you need to get to 70 percent stenosis and that 65 percent is not sufficient. Are you aware that that's -- that was the position taken by Dr. Cammoun and his lawyer?
MR. WEILEIN: And that's a misstatement of the position taken by Dr. Cammoun and his lawyer.
A. I read the article and that was a 1991 article. 1991. And that was the -- the -- the original NASCET trial, yes. They did it on patients with stenosis greater than 70 percent, and it was beneficial.

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Q. So --
A. Since then --
MS. RINDEN: Hold on.
Q. Sorry.
A. Since then the NASCET trial has included patients that have greater than 50 percent, and the conclusion is, yes, they have a benefit if it's greater than 50 percent. The only time they don't get benefit is if it's less than 50 percent, and so since then. So that's a very old article.
Q. When you say "since then," what year are you talking about, approximately?
A. Sometime since the -- I don't know, 2000 and -- since, you know, the modern. Let me just put it this way: Modern. The article he brought was in '91. That's when the original NASCET study -- trial was done.
Q. Okay. Couple things. One, there were three articles produced by Dr. Cammoun's attorney. Did you look at all three articles?
A. I looked at them all.
Q. Okay. And, secondly, let's try to pare down the timeframe that you say that this changes. This surgery is done in 2014. Was it before

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2014?
A. Oh, yes.
Q. Okay. Do you think it was after 2000, the year 2000?
MR. WEILEIN: I'm going to object just because you're mixing apples and oranges. He's already said he only knows about vascular surgery standards, he doesn't know about radiology standards, so you're asking him to comment on things he's not qualified to comment on.
Q. I'm asking about this -- the guidelines you've been talking about from this -- I think you said Society of --
A. Society of Vascular Surgery.
MR. WEILEIN: Right, which Dr. Cammoun is not a member of because he's a radiologist --
MS. RINDEN: Hold on. We've got to --
MR. DIAZ: I'm not interested -- I understand, George. I'm just -- I'm interested in asking him questions based on what he's testified to.
Q. So I'm trying to pin down when was -- when do you think that went into effect? What year, as best you can tell me?

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A. I don't recollect but it's in this day and age, you can Google it. Your partner can look it up right now and tell you.
Q. Okay.
A. The Society of Vascular Surgery guidelines for carotid endarterectomy.
Q. Okay.
A. Symptomatic.
Q. All right.
A. It's there for everybody. It's public information.
MR. DIAZ: All right. All right. Those are the questions I have. I thank you. I appreciate you taking the time.
MS. RINDEN: I just have a couple, Dr. Otoadese.

CROSS-EXAMINATION

BY MS. RINDEN:

Q. I'm looking at Exhibit 7. Do you have that? I can hand you mine. There's a reference there to complex plaque, and I'd like you to describe for us what complex plaque is.
A. The -- the typical plaque is calcified. It's calcified. It's hard. A complex plaque means that it's a mixture of calcified and soft and

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ulcerated plaque, so that's what I meant by "complex." It's not just a regular plaque that's calcium. It's got mixed things there. It's -- it's irregular and ulcerated. That's important because the risks of embolization and a stroke from the plaque is very high when it's ulcerated and irregular.

Q. The records indicate that you sent a surgical specimen or tissue to pathology for evaluation. I'm going to hand you a pathology report. It's found at Allen Hospital page 243. Doctor, can you tell us first of all what specimen did you send in for a pathology evaluation?

A. It's the -- the plaque from the carotid artery surgery.

Q. So it was the plaque that you removed during Mr. McGrew's surgery?

A. Yes.

Q. And what -- what were the dimensions of that plaque that you removed during surgery, according to the pathology report?

A. Yeah, according to the report, it's four centimeters long and two centimeters wide tubule of hard and rubbery, yellow-orange tissue.

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Q. All right. And you mentioned earlier today that you are not a radiologist but that you look at your own imaging for your patients. Is that right?

A. I do, right.

Q. Can you explain to the jury why you look at the imaging yourself for your patients?

A. So I understand what the radiologist is saying and how I can explain it better to the patient. I usually show them the imaging. I show it to them, I point out what the report is saying, and we go from there, but I look at all of them.

MS. RINDEN: All right. Those are all the questions I have.

MR. WEILEIN: I have no questions.

REDIRECT EXAMINATION

BY MR. DIAZ:

Q. What's the significance of this four centimeter by two centimeter?

A. It's -- it's -- it's a good -- That's the plaque I took out because I send them off. It's irregular, it's mixed, and it's ulcerated, which increases the risk quite a bit for a stroke, embolization from the plaque. If I --

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if I did not send a specimen, I'll have no -- no feet to stand on because this is what I took out, and there is no way that the plaque -- the size of that plaque, if you put in the internal carotid artery, you still have -- you have 70 percent open.

Q. That's what I was going to ask you.

A. It's impossible.

Q. I'm sorry. That's what I was going to ask you is are you able to -- does the two-centimeter wide, for example --

A. Yes.

Q. -- that would be like 20 millimeters; right?

A. That -- yeah, that's an inch. Two and a half is an inch.

Q. How does that -- how does that tell us, if anything, about what it would have looked like before it was removed? In other words, how much of a stenosis would there be?

A. Yes. It -- The pathologist will tell you. When I take it out, I try to pull the whole thing in one piece, so you could see the common carotid, the bifurcation, the plaque going into the external, and the plaque going into the internal, so the whole thing. So the

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pathologist can look at it and tell us if the -- the -- the -- the morphology of the plaque because morphology is very important.

Q. Okay. But can you, based on this four-by-two-centimeter piece of pathology, tell us how that converts to millimeters in terms of what might have been stenotic or making it harder to pass blood through?

A. You can make measurements. You can go back and measure the -- the internal carotid, the common carotid, and then see how this plaque will fit in there and estimate, but --

Q. You didn't do that.

A. No.

Q. And did you during surgery itself try to measure the -- the width of the -- the open artery once you were done?

A. I estimated it but not with calipers or anything, no.

Q. Okay.

A. But I opened it, I looked. We -- we all talked about it and so in every case, actually.

Q. Right.

A. "Wow, look at this. You know, it's almost occluded, and they're saying it's 50 percent."

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We talk about it, you know, commonly.
MR. DIAZ: Okay. All right. I appreciate your time. Thank you, sir.
THE WITNESS: I'd like to add -- It's important -- Jennifer, maybe I should not talk about it, this CD that I have. Want me to mention it?
MS. RINDEN: Well, we've got HIPAA -- HIPAA issues, so we can't be referencing patient names. I think we'll wait on that.
THE WITNESS: Okay. Maybe a jury will see that.
MS. RINDEN: Yeah. We'll figure that out.
MR. DIAZ: All right. So -- so that I'm clear, since this is my opportunity to talk to you --
MS. RINDEN: Yeah.
MR. DIAZ: -- apparently you have a CD of other patients?
THE WITNESS: I wanted to show you an example of how complicated this can be. I have an elderly patient who was sent to me by Dr. Bekavac.
MS. RINDEN: We'll just do it.
MR. DIAZ: Well, I don't want to violate

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that patient's privacy.
THE WITNESS: No name, no name.
MR. DIAZ: Without names.
MS. RINDEN: Hold on. Let's just go off the record for a second.
THE VIDEOGRAPHER: Going off the record. The time is 12:29 p.m.
(An off-the-record discussion was held.)
THE VIDEOGRAPHER: We're on the record. It's 12:29 p.m.
THE WITNESS: Okay. This -- this patient was sent to me by a neurologist, Dr. Bekavac, for evaluation for -- this was in December for carotid surgery. The patient -- the patient's family complained that -- They took her to see Dr. Bekavac because she was not acting right. She was confused and wasn't walking right, like she was limping, and her speech wasn't very clear and things like that. So they took her to Bekavac, and he saw her and ordered a CT angiogram of the carotid.
The -- the report came back. The radiologist in Minnesota who read it said the right side of the carotid artery was 50 percent stenotic. The left-side internal carotid was

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57 percent stenotic. Dr. Bekavac saw it and disagreed and --and said, "Oh, no, no, no. It's 85 percent stenotic on the right and 75 percent stenotic on the left."
So based on that, he sent -- he sent the patient to me for surgery. Eighty-five percent blocked, so I saw the patient. These mental status changes might be coming from the carotid. And I saw the patient and wasn't convinced that her symptoms are from the carotid, but I was -- this case was already on my mind, this case -- Mr. McGrew's case, and I thought, okay, I'll do a little test here.
So I had Dr. Halloran look at the CD, look at the same study, and Dr. Halloran read the same study that Dr. Bekavac had read and said -- he called me and said, "Well, I" -- "I don't" -- "I can't get it more than 68 percent stenotic on the right, 64 percent stenotic on the left."
Okay. Then I said, all right. Let's do this with Cammoun, you know. He's a radiologist. He's not aware of any of this. He's at ADI. So let's have him look at it too. Dr. Cammoun looks at it, and he says the right

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is 55 percent stenotic, the left is 58 percent stenotic. So here we are, you know. Two radiologists -- three radiologists, actually, and a -- a neurologist with all this stuff.
Just was the 6th, two days ago, while preparing for this deposition, I had another radiologist, Dr. Halloran's partner, look at it, this same study, and we looked at it together. He showed me how he was doing the measurements and everything. He came up with 55 percent stenosis on the left and 50 percent on the right. Okay. You have the dilemma.
If I operated on that same patient based on what Dr. Bekavac had recommended, and the patient suffers a stroke, there will be a lawsuit. There may be a lawsuit, and the radiologists obviously will be expert witnesses saying, "Why did you operate? It's 50 percent stenosis. It's not indicated."
If I did not operate on this patient, which I have not yet -- I'm biting my fingers every day -- and the patient suffers a stroke, Dr. Bekavac will be the expert witness saying, "What were you thinking? It's 85 percent stenotic here and 70 percent stenotic and you

didn't do surgery?" That's what we face, and that's the difficulty in making the decision.

Q. (By Mr. Diaz, continuing) Okay. And this patient was symptomatic?

A. Right. Depends on how you say it. I told you what the family said, that she wasn't walking right and she was confused and her speech wasn't quite ---

Q. Mr. McGrew said he had transient loss --

A. I know so --

Q. -- of vision. It's based on patient history.

A. Well, yes, that's what I'm saying. That's what we face, so I have not operated on this patient. I just thought we'd just wait because my gut feeling is that she's not -- this is not what's causing her -- especially when we get this variation. You know, I'm thinking, okay, here we go again, you know.

Q. Okay.

A. Hope -- Luckily, I don't have too many of these to -- to discuss, but it's a difficult and complex problem.

Q. And remind me, did you say that the Society of Vascular Surgeons guidelines are symptomatic plus 50 percent or greater or more than 50

percent?

A. Fifty percent or greater.

Q. Well, under that --

A. For symptomatic.

Q. Under that analysis, all of these people give you the basis for surgery. Correct?

A. Correct. Then why -- You know, that's what I'm saying. That's -- You know.

MR. DIAZ: Okay. All right. Thank you, sir. Appreciate you taking time.

RECROSS-EXAMINATION

BY MS. RINDEN:

Q. And just for clarification, is it your belief that the -- that symptoms that the patient's family complained of were not caused by carotid, based on your evaluation?

A. Yes, correct.

Q. Okay. So in your mind, that is not a symptomatic patient.

A. Yes. Correct.

MS. RINDEN: Okay. All right. That's all we've got.

THE VIDEOGRAPHER: This concludes the videotaped deposition of Dr. Otoadese. We're off the record at 12:36 p.m.

(Deposition concluded at 12:36 p.m.)

CERTIFICATE

I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby certify that there came before me at the date, time and place hereinbefore indicated, the witness named on the caption sheet hereof, who was by me duly sworn to testify to the truth of said witness's knowledge touching and concerning the matters in controversy in this cause; that the witness was thereupon examined under oath, the examination taken down by me in shorthand, and later reduced to computer-aided transcription under my supervision and direction, and that the deposition is a true record of the testimony given and of all objections interposed.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the action.

Dated at Cedar Rapids, Iowa, this 19th day of March, 2018.

Julie M. Kluber

Certified Shorthand Reporter

Cedar Valley Medical SPECIALISTS P.C.

September 26, 2014

RE: William McGrew
[redacted]

Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

Ivo Bekavac, MD, PhD
Dept. of Neurology
1753 W. Ridgeway Avenue
Suite 112
Waterloo, IA 50701
319.833.5954
FAX 319.833.5955

HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is approximately 40%. Subsequently Dr. Otoadese performed right carotid artery endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation. The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

PAST MEDICAL HISTORY: Hypertension.
SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.
FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.
ALLERGIES: None.
PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.
Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16.
HEENT: Head is atrauinatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.
Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.
Heart: Regular rhythm and rate. No murmur.
Lungs: Clear to auscultation and percussion.
Abdomen: Not examined.
Extremities: No clubbing, cyanosis or edema.
NEUROLOGICAL EXAMINATION:
Orientation: He was found to be awake, alert, and oriented X3.
Recent and Remote Memory: Normal.
Attention Span and Concentration: Normal.
Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.
Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.
Sensory Exam: Intact to all modalities.
Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor.
Gait: He is in a wheelchair, unable to walk
Language: Intact.
Fund of Knowledge: Normal.
Speech: Normal.
Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:
1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.
2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.
3. Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:
1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
2. Obtain an MRI of the lumbosacral spine.

3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discrepancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.
4. Reevaluate the patient in one month or earlier as needed.
5. The patient will be notified as well as his family regarding MRI findings.

6. Spent one hour with the patient and his family as well as reviewing records

Ivo Bekavac, M.D., Ph.D.

IB/ts/wkm

10/30 RW

To: BEKAVAC,IVO MD From: AMH Radiology Services

of the person to whom it is addressed. Any further disclosure is strictly prohibited. If you have received this copy in error, please notify us immediately by telephone at 319-235-3715

Allen Memorial Hospital
MCGREW,WILLIAM M
[redacted]
WATERLOO, IA 50702

[redacted]

ADMITTING DR: BEKAVAC,IVO MD
ORDERING DR: BEKAVAC,IVO MD
ATTENDING DR:
CC:
MEDICAL RECORD NUMBER: [redacted]

General X-ray
Order No:14ARA24244
PT. LOC:
ADMIT HX:

DOB: [redacted]
FIN#: [redacted]

THIS COPY TO DR. BEKAVAC,IVO MD
DOCUMENT STATUS: **Final**
Exam Date:10/01/2014

PROCEDURE(S):
OUTSIDE FILMS FOR REVIEW OR READING

REASON FOR EXAM:visual disturbance reading of outside films

CONSULTATION/REVIEW OF OUTSIDE FILMS:

I have been consulted to review a CT angiogram performed on William McGrew at ADT on August 18, 2014. The examination was reviewed on a 3-D physician workstation. Volume rendered and maximum intensity projection images were generated and reviewed

FINDINGS:
Aortic arch: Type II aortic arch. Minimal calcific atherosclerosis aortic arch. Minimal atherosclerosis in origin of the left common carotid artery without a hemodynamically significant narrowing. Origin of the right innominate and left subclavian arteries widely patent.

Right carotid: Small focus of calcific atherosclerosis at the origin of ICA producing a 32% diameter stenosis. The post bulbar cervical ICA is widely patent.

The minimal right ICA diameter measures 3.2 cm. Post bulbar normal ICA diameter measures 4.7 cm

Left carotid: Heterogeneous atherosclerosis of the carotid bulb producing 22% maximal lumen diameter stenosis of the proximal ICA. The post bulbar cervical ICA is widely patent. Circumferential noncalcified moderate stenosis of origin of ECA.

The minimal left ICA diameter measures 4.2 mm. Post bulbar normal ICA lumen diameter measures 5.4 cm.

Bekavac 014

Exhibit 6, Page 1

MCGREW,WILLIAM M Order No: 14ARA24244

'ertebrals: Short segmental heterogeneous atherosclerotic plaque
›roducing near occlusive narrowing of the distal right vertebral
ırtery and focal noncalcific moderate stenosis of the distal left
'ertebral artery.

lso

'igned by: John I Halloran MD on 10/9/2014 2:23 PM
Report created with Powerscribe 360

Bekavac 015

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,** **Defendants**	)	**NO. LACV130355** **PLAINTIFF WILLIAM MCGREW'S SECOND SUPPLEMENTAL ANSWER TO INTERROGATORY NO. 16 PROPOUNDED BY DEFENDANT OTOADESE (Treating Physicians)**

COMES NOW Plaintiff William McGrew and hereby submits his Supplemental Answer to Interrogatory No. 9 propounded by Defendant Otoadese in the above case.

/s/ Martin A. Diaz
Martin A. Diaz 000009676
ICIS AT0002000
1570 Shady Ct NW
Swisher, IA 52338
319-339-4350
319-339-4426 fax
marty@martindiazlawfirm.com
Attorney for Plaintiffs

Copy: Counsel of Record on December 18, 2018

16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

(a) The educational and occupational background of the expert;

(b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;

(c) The subject matter or area on which each expert will testify;

(d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;

(e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also requires that for an expert retained in anticipation of litigation or for trial the expert shall SIGN the answer. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(c)

Dr. John Musgrave, Dr. Matthew Smith, Dr. Richard Mauer, Dr. Ivo Bekavac, and Dr. John Halloran may testify pursuant to previously produced medical records and Plaintiff's Designation of Experts, filed February 6, 2018.

Dr. Bekavac will testify as to the standard of care, causation, and permanency. In his medical record dated September 26, 2014, Dr. Bekavac reviewed the CTA and determined a stenosis of the right ICA of approximately 40%. 40% stenosis is not sufficient to justify endarterectomy. The first and therefore the second endarterectomy were unnecessary and violated the standard of care. Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Halloran, in his medical record dated October 9, 2014, reviewed the CTA and assessed a stenosis of 32%. Dr. Cammoun and Dr. Otoadese misread the CTA and

violated the applicable standard of care. Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Musgrave may be asked to testify about Bill McGrew's medical history before and after his stroke and his care and treatment of Bill McGrew.

Dr. Maurer may be asked to testify about his care and treatment of Bill McGrew.

Dr. Smith has provided handwritten responses to questions propounded by Kent Jayne and those responses are part of the report prepared by Mr. Jayne. In addition, Dr. Smith may be asked to testify to his care and treatment of Bill McGrew.

SECOND SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(c)

In addition to the individuals noted in the "Supplement to Interrogatory 16 Pursuant to IRCP 1.500(2)(c)", Plaintiffs may call:

Allyson Landphair, ARNP, Northern Iowa Cardiovascular And Thoracic Surgery Clinic, P.C.;

Aubrey Donlea, PCT at Allen Memorial Hospital;

Rita Borrett, RN at Allen Memorial Hospital; and

Cydney Capps, PCT at Allen Memorial Hospital

to testify to their observations, assessment and care and treatment of Bill McGrew on September 3, 2014 and thereafter (in the case of Ms. Landphair) as outlined in the Allen Hospital medical records of Bill McGrew.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.** **Defendants**	)	**NO. LACV130355** **PLAINTIFFS' FIRST MOTION IN LIMINE**

COME NOW the Plaintiffs and move the Court in limine to prohibit Defendants, their counsel and any witnesses called to testify by the Defendants and their counsel, from offering any evidence or making any mention whatsoever of the following matters during any part of the trial of this cause, including but not limited to, voir dire examinations of the jury, opening statements, the presentation of evidence or closing arguments:

1. **Evidence or Claims that Plaintiffs were at fault**: Evidence regarding the fact that Plaintiffs were at fault or should have done something different to have prevented harm is inadmissible in this case and should be excluded as irrelevant and unfairly prejudicial. Iowa R. Evid. 5.412 and 5.403.

No claim of comparative fault has been made by Defendants.

2. Asking why or when Plaintiffs filed suit or their personal criticisms: Decisions regarding when and whom to sue and when and whom to dismiss are decisions made by counsel, with the consent of the clients. The Plaintiffs are not medical experts and have not been counseled by any experts. They are lay people and asking the Plaintiffs what criticisms they have or why they sued the defendants are improper opinion questions, as well as an invasion of the attorney-client privilege and relationship and invasion of the mental impressions of counsel. They are ultimately irrelevant as the only opinions that have probative value are those that come from experts. Plaintiffs rely upon Iowa Rule of Evidence 5.401 and 5.403 for the exclusion of this potential evidence, as well as the attorney-client privilege for the associated litigation and trial strategy.

3. Criminal Charges: Bill McGrew was convicted of OWI in 1992 and was charged with theft in the 1980s but the charges were dismissed. Any questions related to any criminal charge is irrelevant, potentially prejudicial and inadmissible as character evidence. Plaintiffs rely upon Iowa Rule of Evidence 5.401, 5.403 and 5.404 for the exclusion of this potential evidence.

4. Other litigation: Any questions related to other litigation, including a prior bankruptcy filing, is irrelevant, potentially prejudicial and inadmissible as

character evidence. Plaintiffs rely upon Iowa Rule of Evidence 5.401, 5.403 and 5.404 for the exclusion of this potential evidence.

5**. Any other alleged cause of harm to Bill McGrew:** Beyond the opinions already expressed in the defense experts' 1.508 disclosures or deposition testimony, Defendant has not provided notice about defense theories of an alternative cause of harm to Bill McGrew. Plaintiffs seek to avoid the prejudice that would result if Defendants' experts come up with a new theory on his condition. Iowa Rule of Civil Procedure 1.508(4) provides as follows:

> **1.508(4) Expert testimony at trial.** The expert's direct testimony at trial may not be inconsistent with or go beyond the fair scope of the expert's disclosures, report, deposition testimony, or supplement thereto.

"The purpose of rule 1.508(4) 'is to avoid surprise to litigants and to allow the parties to formulate their positions on such evidence as is available.'" *West Realty, Inc. v. Fox*, 2009 Iowa App. LEXIS 593, 5-6 (Iowa Ct. App. June 17, 2009) (quoting *Millis v. Hute*, 587 N.W.2d 625, 628 (Iowa Ct. App. 1998)).

"An expert may not express a mere guess or conjecture, but he may testify to what might have been the cause of a certain result." *Millis v. Hute*, 587 N.W.2d 625, 628 (Iowa Ct. App. 1998). Here, any new theory regarding Bill's injuries would be mere guess or conjecture on the part of an expert or would have been made without providing adequate notice to Plaintiffs and should therefore be excluded. Without some type of expert link on cause of an injury for any new

theory, the probative value of any comment or evidence on such a theory would be substantially outweighed by the danger of unfair prejudice, confusion of the issues, and misleading the jury.

Thus, based on Iowa R. Civ. P. 1.508 and Iowa Rules of Evid. 5.401 and 5.403, any evidence suggesting a new theory on the cause of harm to Bill McGrew should be excluded from trial.

6. Limiting Defense Experts to the Fair Scope of Testimony Provided in Discovery: Additionally, as noted in ¶5, Plaintiffs request the Court enforce Rule 1.508(4) and limit defense experts to the "fair scope of the expert's disclosures, report, deposition testimony, or supplement thereto."

7. Bill McGrew's General Medical Records. Bill McGrew's records from the summer of 2014 through the present are probative evidence as these records relate to the incident that is the subject of this action.

However, the general health records of Mr. McGrew contain confidential medical information that is unrelated to the incident at issue. Unless Defendant can establish some reasonable relationship between the record and the issues involved, this Court should either require redaction of those records or exclude the records as irrelevant. Even if Defendants can suggest a potentially relevant use for the records, the records are still subject to Iowa Rule of Evidence 5.403, and without the assistance of an expert to put the document into context, there is a significant chance

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

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COME NOW the Plaintiffs and in response to Defendant Otoadese's Motion in Limine states:

1. **Informed Consent Theory**: Plaintiffs have pled a cause of action for negligence to include a claim of informed consent. Defendants have been aware of this theory since the filing of the lawsuit. Dr. Otoadese was asked questions in his deposition regarding alternative treatment to surgery and the risks and benefits of the alternative treatment, including the option of proceeding without surgery. Dr. Otoadese has conceded that he did not discuss the option of medical therapy (medications) with Mr. McGrew and his daughter. In addition, Defendants were present when Dr. Adams (plaintiffs' retained expert) was asked questions at his

deposition regarding the alternative treatment of medical therapy for ulcerative plaque, a condition that Dr. Otoadese concedes existed on August 18, 2014.

Rather than file a Motion for summary judgment on informed consent, defendants have chosen to file a motion in limine and place the court in the unenviable position of having to determine how the evidence will come in at trial without the benefit of all evidence on the issue. Defendants have chosen to selectively provide evidence regarding this issue, including choosing to ignore Dr. Otoadese's testimony on this issue.

Plaintiffs contend that a motion in limine is not the appropriate vehicle to deal with this issue. If the plaintiffs fail to prove this theory, then the court can grant a directed verdict. To prevent plaintiffs from even attempting to prove their claim, by limiting the evidence that they can offer, would constitute reversible error. Plaintiffs are entitled to the opportunity to present evidence on any theory or cause of action. It is unfair to require the plaintiffs to provide a preview of how they intend to prove this claim through the vehicle of a motion in limine. Plaintiffs have briefed the law on informed consent and the defendants have provided their viewpoint of the law in their motion in limine. Plaintiffs have provided the court with proposed jury instructions on the issue of informed consent. Plaintiffs refuse to provide defendants with an explanation of how they intend to handle the issue of informed consent in this case and the court should not reward the defendants for

failing to bring this issue to the court's attention via a Motion for Summary Judgment.

> The primary purpose of a motion in limine is to avoid disclosing to the jury prejudicial matters which may compel declaring a mistrial. The trial judge is thereby alerted to an evidentiary problem which may develop in the trial. It should not, except upon a clear showing, be used to reject evidence.

State v. Johnson, 183 N.W.2d 194, 197 (Iowa 1971).

There is no proper basis for the defendant to ask this court to rule on the admissibility of evidence of a legitimate cause of action through a motion in limine.

2. Lost Chance Theory: In *Wendland v. Sparks*, 574 N.W.2d 327, 329 (Iowa 1998), the Iowa Supreme Court held that it is not necessary to plead loss of chance.[1]

In his deposition, Dr. Adams testified that after Mr. McGrew was found to have signs and symptoms of a stroke on the morning of September 3, 2014 that there was still an opportunity to take him back to surgery to revascularize the artery, and in his opinion that such a timely effort would have resulted in avoiding the disabling condition that Mr. McGrew now lives with. The defendants disagree with that contention and claim that any such effort would not have changed the

[1] Defendants contend that *Wendland* nevertheless requires that the parties be alerted to the claim. This contention was rejected by the Court in *Mead v. Adrian*, 670 N.W.2d 174, 176-77 (Iowa 2003). The Court there cited to *Wendland* as support for the trial court permitting "amendments to conform to proof that added claims for….lost chance of survival".

outcome. Accordingly, the jury will have to determine if there was an opportunity that was lost because of inaction.

The jury's principal role will be to determine if the original carotid endarterectomy was necessary. The jury could conclude that surgery was necessary, but also conclude that there was a reasonable opportunity to repair the damage done by the original surgery and that Dr. Otoadese was negligent in not attempting to do so. The jury will then have to determine whether it would have made any difference and could come to the determination that there was a lost chance of a better outcome.

Defendants complaints are several. First, they claim that loss of chance was not pled. As noted above, this argument fails because loss of chance does not need to be pled and can in fact be permitted as late as during trial. Defendants further argue that they were unaware of this issue. However, they were clearly aware that Dr. Adams contended that the failure to return Mr. McGrew to surgery on the morning of September 3, 2014 was negligence and that such negligence was a cause of harm to Mr. McGrew. (See also Plaintiffs' Exh. 106). They also knew that their own experts would contend that it would not have made a difference. They knew that there was a dispute as to a chance of recovery from the stroke occasioned by the original surgery.

Second, they argue that Dr. Adams has testified to a traditional negligence claim and therefore loss of chance is not part of the case. This is also mistaken. In their trial brief, plaintiffs cite to *Mead v. Adrian* at 180, fn. 5, which holds, among other things, that "when the claim is submitted as an alternative to ordinary wrongful-death damages it is unrealistic to require a claimant who is arguing that it is more probable than not that death resulted from the defendant's negligence to also present evidence that the probability of survival was in fact some lesser percentage. The jury must determine the amount of proportionate reduction based on all of the evidence in the case."

Third, they appear to disagree with Plaintiffs' proposed jury instructions on how this theory is to be analyzed by the jury. However, that is not an appropriate issue on a motion in limine. That is a discussion to be held during the jury instruction conference. The issue before the court is whether the plaintiff should be permitted to go forward with a theory of recovery that has been recognized by the Iowa Supreme Court. Plaintiffs do not see how the defendant can ask this court to prohibit evidence about a subject that is an integral part of the factual record. If defendants are correct that it is a separate specification of negligence, and not a loss of chance claim, then the evidence still comes in for purposes of assessing that claim.

3. Treating Healthcare Providers: Defendants' Motion in Limine to limit the expert testimony of Drs. Bekavac and Halloran is based on the mistaken belief that plaintiffs have failed to produce an expert report as required by Iowa Rule of Civil Procedure 1.500(2)(b). The argument then follows that, because an expert report has not been produced, Plaintiffs are not permitted to offer testimony from these physicians as to the standard of care and the breach of the standard of care.

As will be discussed below, Plaintiffs complied with the court's discovery plan and the more applicable rule, Iowa Rule of Civil Procedure 1.500(2)(c). Accordingly, Defendants' motion in limine must be denied.

a. Plaintiffs Have Properly Designated Their Expert Witnesses and Disclosed Their Proposed Testimony

The applicable discovery plan required that plaintiffs designate their expert witnesses by February 7, 2018. Plaintiffs complied with that requirement. (Plaintiffs' Exh. 103)[2]

The discovery plan then stated that "any disclosures required by Iowa Rule of Civil Procedure 1.500(2)(b) will be provided" by March 7, 2018. That rule states in relevant part as follows:

> Unless otherwise stipulated or ordered by the court, this disclosure must be accompanied by a written report—prepared and signed by the witness—*if the witness is one retained or specially employed to provide expert testimony in the case* or one whose duties as the party's employee regularly involve giving expert testimony.

[2] All exhibits cited to will be found at the end of this document.

(Emphasis added)

This rule only applies to retained experts. Drs. Bekavac and Halloran, the focus of Defendants' motion, are treating physicians, and were not retained or specially employed to provide expert testimony in this case. Therefore, the discovery plan's requirement that an expert report be provided does not apply to them. The discovery plan is silent as to those individuals that are not retained or specially employed. Those individuals are governed by Iowa Rule of Civil Procedure 1.500(2)(c), which provides as follows:

> *Witnesses who do not provide a written report*. Unless otherwise stipulated or ordered by the court, if the witness is not required to provide a written report, this disclosure must state:
>
> (1) The subject matter on which the witness is expected to present evidence under Iowa Rules of Evidence 5.702, 5.703, or 5.705.
>
> (2) A summary of the facts and opinions to which the witness is expected to testify.

(Emphasis added). The rule is plain and simple. There is no requirement that a report be provided for Drs. Bekavac and Halloran. However, plaintiffs must provide a summary of the facts and opinions to which the witness is expected to testify. Plaintiffs complied with that requirement on March 7, 2018 when it produced a supplemental answer to interrogatory for treating physicians. (Plaintiffs' Exh. 105). The initial answer to interrogatory, which is found in Exhibit

102 identified several treating physicians including Drs. Bekavac and Halloran and provided the following statement:

> The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

The supplemental answer to interrogatory went into greater detail regarding both Drs. Bekavac and Halloran. (Plaintiffs' Exh. 105). This included disclosure that these individuals would testify to the standard of care and the breach of the standard of care.

In addition, plaintiffs had already produced as part of the initial disclosures all medical records including the records of Drs. Bekavac and Halloran. The medical records produced include Exhibits 11, 12 and 13, which detail the key opinions held by both treating doctors, namely that the CT angiogram read by Dr. Otoadese does not demonstrate right carotid artery stenosis of 70%. Rather, Dr. Halloran contends that the correct reading of that CT angiogram is 32% and Dr. Bekavac contends that the correct reading of that CT angiogram is no more than 40%. Dr. Bekavac also opined that because the CT angiogram was misread there was no justification for the surgery that was performed on Mr. McGrew.

Accordingly, Plaintiffs complied fully with the disclosure requirement of IRCP 1.500(2)(c).[3]

Defendants' contention that Plaintiffs were obligated to provide an expert report pursuant to the retained expert disclosure rule is simply mistaken. These doctors were treating physicians. As such, Plaintiffs had no obligation to obtain a written report from each. In fact, that's contrary to the entire framework of the disclosure requirements. The intent and purpose of the rules is to recognize that, when it comes to treating physicians, Plaintiffs have little to no control over those individuals. That is totally different than the scenario in which Plaintiffs go out and hire or retain an expert for the purpose of testifying at trial. In that scenario, Plaintiffs can obtain a report prepared by the retained expert. Treating physicians are not required to prepare special reports because they've not been retained for that purpose. Rather, treating physicians can rely upon any progress notes or medical records that they have generated themselves in the care and treatment of the plaintiff and can rely on the mental impressions they developed during the treatment process and any opinions formed from the facts obtained and impressions made.

[3] Defendants contend that these medical records are hearsay and may not be admitted. Plaintiffs disagree, but regardless, these records identify the facts and opinions that these doctors developed at the time they saw Mr. McGrew or his imaging studies.

The Iowa rules recognize that treating physicians can develop mental impressions and opinions arising out of the care and treatment that they provide. That is certainly what happened here regarding Drs. Bekavac and Halloran. They are not required to provide expert reports. Plaintiffs have otherwise complied with the Iowa rules.

b. Defendants were given the opportunity to depose Drs. Bekavac and Halloran and waived that right

Over a 5-month period, Defendants were given the opportunity to depose these treating physicians. After demanding their depositions, the defendants did an about face and withdrew their requests. Defendants waived their right to depose these treating physicians.

Iowa Rule of Civil Procedure1.508(1)(a) allows a party to "depose any person who has been identified as an expert whose opinions may be presented at trial." This rule is not limited to retained experts but, if experts are retained, then their depositions can only take place after they have produced written reports. In the case of Drs. Bekavac and Halloran, since they were not retained, their depositions could be taken at any time.

In their Motion to Strike Experts, plaintiffs provide an extensive history that shows that Plaintiffs made these two treating physicians available for a deposition. In the case of Dr. Halloran, all efforts to depose him went through his own lawyer. As for Dr. Bekavac, Plaintiffs provided a direct phone number where they could

contact Dr. Bekavac to schedule his deposition. After many months of efforts to obtain deposition dates from counsel for the defendants, the parties agreed on 2 days in January 2019 for the depositions of these two treating physician experts. Yet, shortly after those dates were agreed to, the defendants canceled the depositions and waive their right to take those depositions. (Plaintiffs' Exh. 202).

c. An IRCP 1.500(2)(c) disclosure is the equivalent of an IRCP 1.500(2)(b) report, especially when supported by medical records produced by the treating physician

In this case, Plaintiffs provided two forms of expert disclosure regarding the proposed testimony of these treating physicians. First, they provided the medical records generated by these physicians. These are business records that are made as part of medical diagnosis or treatment and are therefore admissible. They detail the thought process of both physicians and provide an outline of those facts, mental impressions and opinions formulated at the time they provided care and treatment. Second, Plaintiffs provided the expert disclosures required pursuant to IRCP 1.500(2)(c).

Defendants' complaint is that they have not been provided with an "expert report" under IRCP 1.500(2)(b). But what they fail to acknowledge is that they have been provided with the equivalent if not more than an expert report. The medical records alone provide a clear statement of what Dr. Bekavac was thinking, the concerns he had raised with the family, and his belief that he needed to confirm

that information by having Dr. Halloran review the CT angiogram. That's significant information to put in a medical report. It is a rare event when a physician criticizes another physician in the medical chart. It is not uncommon for one physician to raise concerns with patients about the care provided by another physician, but it is exceedingly uncommon for those thoughts and opinions to find their way into the patient's chart. The purpose of an expert report as requested by these defendants is to alert them to the potential line of testimony of the expert witness. The medical records prepared by Drs. Bekavac and Halloran tell a very direct story. Defendants' contention that they need a separate expert report is meritless.

In addition, these defendants also received supplemental answers from the plaintiffs stating that they intended to utilize the testimony of these treating physicians as part of the proof of negligence in this case and outlined that evidence. Defendants recognized the potential testimony because they sought to take the depositions of these individuals.

When the Supreme Court authorized the change to the rules regarding expert disclosures, it sought to create equivalencies in different experts.[4] It recognized

[4] The changes were generally outlined in an August 28, 2014 order issued by the Supreme Court. The overall changes to the discovery process came in response to the Iowa Civil Justice Task force report issued in 2012. A review of the Task Force report reflects that the task force could not come to an agreement regarding changes to the expert disclosure requirement. It appears that the Supreme Court created this system on its own without a specific recommendation from the task force. The changes went into effect in 2015.

that in some cases there will be expert witnesses that are not retained or specially employed for purposes of litigation. In creating the two separate subparagraphs of the rule, the court struck this equivalency by demanding different methods for disclosure. If you retain an expert, you can control that expert and therefore you should be expected to produce an expert report prepared by that expert. On the other hand, if your case happens to have a witness that has special training and skill, you should be able to utilize that individual without demanding that he produce a written report that is the equivalent of what that expert may already have said in other writings. In other words, why should we expect a treating physician to prepare or sign off on an affidavit or report when that physician has already created the equivalent of such a report in the course of their care and treatment of the patient? But the court was also sensitive to the fact that the opposing party would need to know that the witness would be used as part of the case. Therefore, the court created a separate but equal mechanism to an expert report from a non-retained expert that balanced these concerns.

Defendants' argument seeks to undermine the balance created by IRCP 1.500(2). In short, they are demanding an expert report from a treating physician. This argument cannot be allowed to succeed because it then would require a party interested in using a non-retained expert to get an expert report to satisfy the opposing party.

Defendants also contend that *Hansen v. Central Iowa Hospital Corp*., 686 N.W.2d 476 (Iowa 2004) is still good law. It's not entirely clear that it is, but to the extent that it is, the key practice pointer is that if you intend to use treating physicians to discuss matters beyond their role as treaters then you should make disclosure. The disclosure rules in existence at the time that *Hansen* was decided are different than the current rules. So long as one complies with the disclosure rules in effect at the time of the case, the requirements of *Hansen* are met. Plaintiffs clearly met the disclosure requirements and the defendants have not been prejudiced in any way. They have known about these individuals since the filing of this lawsuit and have chosen not to depose them.

4. Irrelevant and Prejudicial Subjects: Defendants have raised eight separate issues described under the general heading of "irrelevant and prejudicial subjects." Plaintiffs will respond to each by indicating the letter applicable to the request:

a. **Criticism of physicians by other physicians:** It is a fact in this case that Dr. Bekavac disagrees with the interpretation of the CT angiogram of August 18, 2014 and is critical of the decision to perform surgery on Mr. McGrew. It is also a fact that Dr. Halloran disagrees with the interpretation of the CT angiogram of August 18, 2014. Such criticisms are usually reserved, if at all, for the peer review

process. That didn't happen here. Plaintiffs should be permitted to establish these facts and should not be limited in the words they use to describe these facts.

b-c. **Dr. Otoadese's qualifications:** Dr. Otoadese has testified that in 2008-2009 he "voluntarily" surrendered his hospital privileges to perform heart surgery, which at the time constituted 50-60% of his overall time performing surgeries. Dr. Otoadese then filed suit against Allen Memorial Hospital relating to these surrendered privileges and reached a confidential settlement unknown to these Plaintiffs. (*See Otoadese v. Allen Memorial Hospital*, Black Hawk County, LACV114625). But, notwithstanding that settlement, Dr. Otoadese has not performed "open heart" surgeries since 2009. He has admitted that at the time he was performing "open heart" surgeries, they constituted 50-60% of his surgery time and approximately 30% of his overall surgeries.

In 2012, Dr. Otoadese was "kicked out" (terminated)[5] from Cedar Valley Medical Specialists and on January 1, 2013 he opened Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. In the summer of 2014, Dr. Otoadese's surgeries were limited to vascular and nonvascular thoracic areas of the

[5] These are Dr. Otoadese's words. He explains in his deposition that he was terminated because CVMS was not able to get insurance to cover his practice. Plaintiffs do not know if that is an accurate reflection of why, but they do not intend to offer that evidence unless the defendant wishes to.

body and he was still not performing open-heart procedures---consistent with the fact that he no longer had privileges to perform open heart surgeries.

One of Dr. Otoadese's experts is Dr. James Levett, a cardio thoracic surgeon from Cedar Rapids. Dr. Levett was retained as an expert witness by Allen Hospital in the lawsuit filed by Dr. Otoadese. Dr. Levett was hired to testify to the appropriateness of the decision to withhold surgical privileges from Dr. Otoadese to perform open-heart procedures.

The above facts are undisputed.

It is also undisputed that on August 18, 2014, Mr. McGrew went to see Dr. Otoadese who recommended surgery and did not discuss with Mr. McGrew alternative treatment for his condition that did not require surgery.

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.

Iowa Rule of Evidence 5.702

Iowa law existing at the time this case was filed, Iowa Code §147.139, provided as follows:

> If the standard of care given by a physician….is at issue, the court shall only allow a person to qualify as an expert witness and to testify on the issue of the appropriate standard of care if the person's medical…qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case.

Dr. Otoadese will testify in his own defense. Dr. Otoadese is an expert witness and he will testify to the fact that he did not violate the standard of care. In order to assess Dr. Otoadese's credibility as an expert, the court must provide the plaintiff the opportunity to question Dr. Otoadese's qualifications including any limitations on his hospital privileges, and the successes and failures that he has had as a physician and surgeon. This includes any motivation that he may have had to perform surgery on Mr. McGrew. The evidence will include the fact that his surgical practice had taken a substantial downturn in 2009 when he was not allowed to perform open-heart procedures. The evidence will also include the fact that his surgical practice was significantly affected by his termination ("kicked out", as he termed it) from Cedar Valley Medical Specialists. In order to properly assess Dr. Otoadese's skill as a physician and his motive for recommending surgery, the jury needs to be given all relevant information. Failure to provide the jury with that information would mislead the jury.

If Dr. Otoadese were called as a retained expert, plaintiffs would be permitted to inquire about the hospital privileges maintained by him and whether he had ever been terminated from a clinical group. That information would be relevant to assess his qualifications to render standard of care opinions.

In addition to the undisputed facts regarding his hospital privileges at Allen Memorial Hospital, and his termination from Cedar Valley Medical Specialists,

there is the additional evidence that one of Dr. Otoadese's expert witnesses has previously testified as an expert witness against Dr. Otoadese in the case involving his privileges to perform open-heart procedures at Allen Memorial Hospital.

This inquiry into the qualifications of any expert, including a defendant who was an expert, has been recognized by the Iowa Supreme Court:

> We are committed to a liberal rule on admissibility of expert testimony, *Wick v. Henderson*, 485 N.W.2d 645, 648 (Iowa 1992), and the admission of such testimony rests within the sound discretion of the district court. *Tappe v. Iowa Methodist Medical Ctr.*, 477 N.W.2d 396, 402 (Iowa 1991). Iowa Rule of Evidence 702 has "codified Iowa's existing liberal rule on the admission of opinion testimony." *Hutchison v. American Family Mut. Ins. Co.*, 514 N.W.2d 882, 885 (Iowa 1994). The United States Supreme Court reaffirmed this approach in *Daubert v. Merrell Dow Pharmaceuticals*, *Inc.*, 509 U.S. 579, 125 L. Ed. 2d 469, 113 S. Ct. 2786, 2799, 125 L. Ed. 2d 469, 485 (1993). Rule 702 provides:
>
> > If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.
>
> Further, in its comments to rule 702, the advisory committee stated:
>
> > *If* [pursuant to Iowa Rule of Evidence 104(a)] *the Court is satisfied that the threshold requirements have been met, the witness should be allowed to testify.* **All further inquiry regarding the extent of his [or her] qualifications go to the weight that the fact finder can give such testimony under Rule 104(e).**

Carolan v. Hill, 553 N.W.2d 882, 888 (Iowa 1996) (Italics in original; bold added)

In *Hutchison v. American Family Mut. Ins. Co*., 514 N.W.2d 882 (Iowa 1994), the plaintiff objected to testimony from defendant's retained expert because

he was not board certified in neuropsychology and because he was a psychologist and not a medical doctor testifying about medical causation. In rejecting this objection, the court took pains to point out that the ultimate assessment of qualifications was left to the trial process including cross-examination and jury assessment of the witness. The court stated:

> Dr. Moore has board certification as a clinical psychologist, holds a Ph.D. in clinical psychology, and has substantial experience in neuropsychology. Although Dr. Moore lacked board certification in neuropsychology, we believe this fact went to the weight of his testimony, not its admissibility.
>
> ***
>
> Although few of these restrictions on experts strike us as fundamentally unsound, we refuse to impose barriers to expert testimony other than the basic requirements of Iowa rule of evidence 702 and those described by the Supreme Court in *Daubert.* The criteria for qualifications under rule 702--knowledge, skill, experience, training, or education--are too broad to allow distinctions based on whether or not a proposed expert belongs to a particular profession or has a particular degree.
>
> ***
>
> We understand the concern that expert testimony regarding the causes of personal injury can fall "wholly in the realm of conjecture, speculation, and surmise." Nevertheless, we agree with the *Daubert* Court that the trial court in its discretion and the jury in its deliberation provide the most effective determination of the admissibility and weight of expert psychological testimony.
>
> ***
>
> Similarly, we believe with the aid of vigorous cross examination, the jury is fully capable of detecting the most plausible explanation of events. ….
>
> ***
>
> Moreover, plaintiffs had ample opportunity to discredit Dr. Moore. Plaintiffs' counsel subjected Dr. Moore to *thorough cross examination regarding his qualifications* and the basis of his testimony, *placing special emphasis on his lack of medical qualifications*. …

Id. at 886-889 (Italics added)

Finally, in *Andersen v. Khanna*, 913 N.W.2d 526 (Iowa 2018), the Court held that the personal characteristics of a physician may establish a duty of disclosure as part of obtaining informed consent for treatment. In discussing the duty to disclose surgical experience, the Court noted the following:

> Indeed, at trial several experts testified regarding the number of Bentall procedures they had performed and their training to perform the procedure in order to establish their competency to testify as expert witnesses. *It stands to reason that if such information is relevant to establishing a witness's expertise, such information could be material to a reasonable patient's decision to or not to undergo a particular treatment.*

Id. at 540 (emphasis added).

The Court cited with approval a Louisiana Court of Appeals decision that "held the physician had a duty to disclose his chronic alcohol abuse." *Andersen* at 542 (citing to *Hidding v. Williams*, 578 So. 2d 1192, 1196 (La. Ct. App. 1991)). The Court makes clear that the qualifications of a physician may be relevant to consent, and in the process highlights that a physician's history is important in assessing their credibility.

Defendants contend that permitting evidence of the qualifications of the defendant physician would be more prejudicial than probative. However, it would be more prejudicial not to tell the jury about the qualifications and working history of this physician. Under what circumstances is the qualifications of an expert physician not probative? Under what circumstances is the working history of an expert physician not probative? They clearly are. If prejudice exists, it does so

because defendant's qualifications create such prejudice. It is not prejudice created by the plaintiffs. If any such prejudice exists, it cannot outweigh the probative value of a jury understanding a physician's qualifications.

d. **Leased Space for Ultrasounds**: The fact that Dr. Otoadese has access to an ultrasound facility is relevant since one of the options he had was to perform an ultrasound on Mr. McGrew's carotid arteries before recommending surgery. The location of that facility is at ADI, where Dr. Cammoun is employed. The fact that Dr. Otoadese leases space from ADI and Dr. Cammoun, and that Dr. Otoadese routinely refers patients to Dr. Cammoun are also relevant to understanding the relationship between these two individuals and why Mr. McGrew ends up there. There is nothing prejudicial about this information.

e. **Financial Motives behind medical care**: Defendants cite to a series of facts that are undisputed. It's not clear what the complaint is. If the defendants' contention is that plaintiffs should not be permitted to comment on the evidence that is admissible then they are mistaken. Again, not permitting reasonable argument from admissible evidence can be more prejudicial than to permit such argument. Apparently, defendants prefer that the jury be kept in the dark about how Dr. Otoadese practices medicine.

f. **Medical Chart**: Plaintiffs don't plan to make this argument but, if the door is opened, they reserve the right to argue this.

g. **Relationships between Dr. Otoadese and Drs. Bekavac and Halloran**: The evidence will be that there is no ill will between all physicians involved. This is relevant because a jury may conclude without such information that there is ill will between these individuals and that is what led Drs. Bekavac and Halloran to criticize the CT angiogram interpretation and the surgery. Therefore, this is probative evidence and there is no prejudice to its admissibility.

h. **Board Certification**: Please refer to the discussion on qualifications in subparagraph b-c. If Dr. Otoadese were first in his class in medical school, the Defendants would be parading that before the jury; but if he struggled to be board certified, the defense would want that excluded.

5. Other patients, claims or adverse outcomes of Dr. Otoadese: Plaintiffs do not intend to discuss specific patients claims or adverse outcomes. However, during his deposition Dr. Otoadese was interested in talking about other patients (not by name). If he persists, then plaintiffs do intend to discuss with him prior lawsuits or adverse outcomes. Defendants do not get to talk about his practice as if it were pristine and without problems.

6. Peer Review: Plaintiffs do not intend to offer any such evidence during their case in chief. However, if Dr. Levett one of defendants' retained experts testifies, plaintiffs intend to ask him about his involvement in the lawsuit filed by Dr. Otoadese against Allen Hospital. Dr. Levett was retained by Allen Hospital to

testify to the decision by the hospital to deny certain surgical privileges to Dr. Otoadese.

7. Out of Court Statements of Health Care Providers: Plaintiffs believe that any out-of-court statements should be handled on a case-by-case basis. This is because some statements made by health care providers to the plaintiffs would not be hearsay because they would either be subject to an exception or because they would not be offered for the truth of the matter asserted but rather offered for other purposes such as state of mind and decision-making.

8. Future Medical Expenses: Iowa Code §147.136 does not allow an award of medical expenses that have been paid for or will be paid for by insurance or a governmental program, with some exceptions. However, that statute does not prohibit evidence of future expenses. It just does not permit recovery if those expenses will be paid for by insurance or a governmental program. The difficulty is that for some expenses there may not be any coverage, or any coverage may be uncertain. Plaintiffs intend to offer the testimony of Kent Jayne about the cost of future life care and Mr. Jayne can testify as to whether those expenses are expected to be covered by insurance or a governmental program. Plaintiffs' principal future life care claim will be related to bringing Mr. McGrew home and providing him with in-home care. This type of care is usually not covered by insurance or governmental program. Plaintiffs anticipate that they will make this distinction

known to the jury during Mr. Jaynes testimony. Plaintiffs contend that it would be error for the court to preclude such evidence. The better approach is to deal with it in the jury instruction process.

9. Liability Insurance Coverage: No objection.

10. Punitive Damages: No objection.

11. Financial Disparity: No objection.

12. Settlement: With the understanding that Dr. Cammoun is a released party under Chapter 668, Plaintiffs do not object to the balance of the request.

Respectfully submitted,

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Cedar Valley Medical SPECIALISTS, P.C.

September 26, 2014

RE: William McGrew
DOB: [redacted]

Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

Ivo Bekavac, MD, PhD

Dept. of Neurology

1753 W. Ridgeway Avenue

Suite 112

Waterloo, IA 50701

319.833.5954

FAX 319.833.5955

HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is approximately 40%. Subsequently Dr. Otoadese performed right carotid artery endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation. The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

PAST MEDICAL HISTORY: Hypertension.
SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.
FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.
ALLERGIES: None.
PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.
Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16.
HEENT: Head is atraumatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.
Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.
Heart: Regular rhythm and rate. No murmur.
Lungs: Clear to auscultation and percussion.
Abdomen: Not examined.
Extremities: No clubbing, cyanosis or edema.
NEUROLOGICAL EXAMINATION:
Orientation: He was found to be awake, alert, and oriented X3.
Recent and Remote Memory: Normal.
Attention Span and Concentration: Normal.
Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.
Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.
Sensory Exam: Intact to all modalities.
Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor.
Gait: He is in a wheelchair, unable to walk
Language: Intact.
Fund of Knowledge: Normal.
Speech: Normal.
Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:
1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.
2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.
3. Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:
1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
2. Obtain an MRI of the lumbosacral spine.

3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discrepancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.
4. Reevaluate the patient in one month or earlier as needed.
5. The patient will be notified as well as his family regarding MRI findings.

6. Spent one hour with the patient and his family as well as reviewing records

Ivo Bekavac, M.D., Ph.D.

IB/ts/wkm

IVO BEKAVAC, M.D., Ph.D.

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EDUCATION:

Medical school: University of Zagreb, Croatia
M.D., September 1989

Ph.D.: University of Zagreb/Hahnemann University, Zagreb/Philadelphia
Ph.D. in Neuroscience, April 1995

CLINICAL EXPERIENCE:

Internship - Clinical Hospital Split, Croatia, 1989-90
Internship - Cleveland Clinic, Cleveland, USA, 1994-95
Neurology residency program - Cleveland Clinic, USA, 1995-98
Staff Neurologist – Waterloo, USA, 1998- present

SPECIFIC TRAINING:

EEG/EP/Epilepsy -Cleveland Clinic, Cleveland, USA, 1996-98(6 months)
Minifellowship in Epilepsy - Bowman Gray School of Medicine, 1997
EMG course -Cleveland Clinic, Cleveland, USA, 1997-98 (6 months)
Neurovascular ultrasound (carotid and TCD)-Cleveland Clinic (1 month)
Neurovascular ultrasound course - Bowman Gray School of Medicine, 1998

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology - 2000
American Board of Electrodiagnostic Medicine - 2001
American Society of Neuroimaging – 2002 (MRI/CT & Neurosonology)
Subspecialty Board in Vascular Neurology, ABPN – 2006
Neuroimaging Subspecialty Board, UCNS – 2013

RESEARCH EXPERIENCE:

Student - research program in clinical cardiology, Department of Cardiology, **Clinical Hospital Split, Croatia,** 1986-89
Post Doctoral Fellow - Department of Anesthesia Research, **McGill University, Montreal, Canada,** 1990-91:

-study of activated ion channels using patch clamp technique (neuroscience-electrophysiology)
-study of speed of action of various muscle relaxants using iontophoresis

Research Associate, Department of Physiology, **Hahnemann University, Philadelphia, USA,** 1991-1994:

-effect of cocaine on the somatosensory signal processing using single unit extracellular recording (in vivo)

Resident-cerebrovascular clinical research, Cleveland Clinic, 1995-98

TEACHING EXPERIENCE:

Teaching Assistant-Department of Physiology, **McGill University,** 1990-91
ACLS Course Instructor -First Croatian World Congress, **Croatia,** 1996
Assistant professor of neurology- Medical School Split
Adjunct associate professor of neurosurgery-University of Iowa Hospitals/Clinics

PROFESSIONAL MEMBERSHIP:

American Academy of Neurology, since 1997

LICENSURE:

1. **Iowa**, since 1998
2. **Ohio**, since 1995
3. **Utah**, since 1995

LIST OF PUBLICATIONS:

Papers:

1. Miric D, Rumboldt Z, Tonkic A, **Bekavac I.** (1989). Out-of-hospital sudden death rate: some peculiarities in circadian rhythm. **Medicina** 25:69-71.

2. Rumboldt Z, Miric D, **Bekavac I.** (1988). The rhythm of dying due to heart stroke during the day. The Second Croatian Symposium on Cardiovascular Disease. 54:61-64.
3. Law Min JC, **Bekavac I**, Glavinovic MI, Donati F, Bevan DR. (1992). Iontophoretic study of speed of action of various muscle relaxants. **Anesthesiology** 77:351-356.
4. **Bekavac I,** Waterhouse BD. (1995). Systemically administered cocaine selectively enhances long-latency responses of primary sensory cortical neurons to peripheral stimuli. **J. Pharmacol. Exptl. Therapeut.** 272:333-342.
5. Waterhouse BD, Gould EM, **Bekavac, I.** (1996). Monoaminergic substrates underlying cocaine-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. **J. Pharmacol. Exptl. Therapeut.** 279:582-592.
6. **Bekavac I**, Hanna JP,Wallace RC, Powers J, Ratliff NB, Furlan AJ, (1997). Intraarterial thrombolysis of myxomatous proximal middle cerebral artery occlusion. **Neurology** 49:618-620.
7. **Bekavac I**, Hanna JP, Sila CA, Furlan AJ. (1999). Warfarin and low-dose aspirin for stroke prevention in patients with severe intracranial stenosis.**Journal of Stroke and Cerebrovasc. Diseases** 8:33-37.
8. **Bekavac I,** Halloran JI. (2003). Meningocele induced positional syncope and retinal hemorrhage. **AJNR** 24:838-839.
9. Halloran JI, **Bekavac I.** (2004). Unsuccessful tissue plasminogen activator treatment of acute stroke caused by a calcific embolus. **J. Neuroimaging** 14:385-387.
10. **Bekavac I,** Halloran JI, Frazier S, Sprung J, Bourke DL. (2006). Chiropractic manipulation induced dissection and subsequent aneurysm formation of the internal carotid artery, or if it ain't broke, don't fix it. **J. Explore** 2:150-151.
11. **Bekavac I,** Goel S. (2011). Transient, unilateral, complete, oculomotor palsy in an adult patient with idiopathic intracranial hypertension. **Signa Vitae** 6(1): 44-46.

Abstracts:

1. **Bekavac, I.** (1989). Functional correlate between air pollution and heart disease. Medical Conference 35:1989.
2. Law Min, J.C., **Bekavac, I.**, Glavinovic, M.I., Donati, F. and Bevan, D.R. (1991). Iontophoretic study of speed of action of various muscle relaxants. Anesthesiology 75:A810.
3. **Bekavac, I.** and Waterhouse, B.D. (1992). Physiological actions of cocaine in sensory circuits: I. Enhancement of rat somatosensory cortical neuron responsiveness to vibrisae stimulation. Soc. Neurosci. Abstr. 18:544.
4. Waterhouse, B.D. and **Bekavac, I.** (1992). Physiological actions of cocaine in sensory circuits: II. Drug-induced alterations in receptive field properties of rat somatosensory cortical neurons. Soc. Neurosci. Abstr. 18:544.
5. Kapural, L., **Bekavac, I.**, Trifaro, J.M. and Glavinovic, M.I. (1992). Effect of 4-aminopiridine on bovine chromaffin cell membranes. Soc. Neurosci, Abstr. 18:794.
6. Waterhouse, B.D., Stowe, Z., Jimenez-Rivera, C.A. and **Bekavac, I.** (1992). Influences of cocaine on the response properties of single neurons in

monoaminergically-innervated sensorimotor circuits. Annual Meeting of Drug Abuse, Puerto Rico.

7. Waterhouse, B.D. and **Bekavac, I.** (1992). Cocaine effects on stimulus coding properties of sensory cortical neurons. Annual Meeting of Drug Abuse, Puerto Rico.
8. **Bekavac, I.** and Waterhouse, B.D. (1993). Physiological actions of cocaine in sensory circuits: I. Identification of monoaminergic substrates underlying drug-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. Soc. Neurosci. Abstr. 19-1855.
9. **Bekavac, I.**, Rutter, J.J. and Waterhouse B.D. (1994). Physiological actions of cocaine in sensory circuits: drug influences on signal transmission through rat Pom and VPM thalamic nuclei. Soc. Neurosci. Abstr. 20:982.
10. **Bekavac, I.**, Wallace, R.C., Powers, J., Ratliff, N.B. and Hanna J.P. (1996). Intraarterial thrombolysis of myxomatous proxymal middle cerebral artery occlusion. First Croatian World Congress 1:12.
11. **Bekavac, I.,** Hanna, J.P. and Sila, C.A. (1997). Warfarin and low-dose aspirin for stroke prevention in patients with severe large arterial intracranial stenosis failing monotherapy. Neurology, 49:A289
12. **Bekavac, I.,** Sethi, P., Wong, C.O. and Hanna, J.P. (1998). Utilizing stress Technetium-99m-ECD brain SPECT in the management of intracranial stenosis. Neurology, 50:A400

BOOK CHAPTERS:

Bekavac I, Pathophysiology of neurological diseases. In: Gamulin S, Marusic M. Pathophysiology, fourth edition, Zagreb: Mladost, 1998:830-860.

LECTURES:

Grand rounds, Cleveland Clinic, May 1998: **Excitotoxicity and Stroke**
Clinical Neuroscience Course, University of Split, June 2000
Clinical Neuroscience Course, University of Split, July 2002

Cedar Valley Medical SPECIALISTS, P.C.

October 30, 2014

RE: William McGrew
DOB: [redacted]

Ivo Bekavac, MD, PhD
Dept. of Neurology

753 W. Ridgeway Avenue
Suite 112
Waterloo, IA 50701
319.833.5954
FAX 319.833.5955

Mr. William McGrew comes in for followup regarding stroke as well as lower back pain. He had MRI of the lumbosacral spine read by Dr. Halloran, reviewed personally and showed to the patient. It is remarkable for lateral disc herniation at the level L3-L4 as well as disc bulging at the level L3-L4 as well as L4-L5. Dr. Halloran did over read CTA and felt that there is ICA stenosis of 32%. While doing physical therapy he is doing better, also he has been doing stroke rehabilitation. He has not noticed any improvement. On examination, there is a complete weakness involving left upper and left lower extremity 0/5 unchanged since initial examination September 26, 2014. He has been also complaining of being depressed and also noticed by his family as well. List of medications reviewed. He is not taking any antidepressants. Apparently, he is on clopidogrel as well as aspirin 81 mg for stroke prophylaxis.

IMPRESSION:

1. Status post right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initial carotid artery stenosis 32% according to Dr. Halloran.
2. Intermittent lumbar sensory radiculopathy with symptomatic improvement. No evidence of lumbosacral motor radiculopathy.
3. Depression.

PLAN:

1. Continue with clopidogrel 75 mg a day as well as aspirin 81 mg a day for secondary stroke prophylaxis.
2. Continue physical therapy and stroke rehabilitation.
3. Star the patient on Lexapro 10 mg a day for depression. Potential side effects were explained to the patient as well as his family.
4. Reevaluate the patient in two months or earlier as needed.
5. Multiple questions were answered.

Ivo Bekavac, M.D., Ph.D.

IB/ts/wkm

PLAINTIFFS' EXHIBIT 12

Clinical Lab Results (continued)

Lab Results

No matching results found

Radiology Results (10/09/14 - 10/01/14)

Xray consultation referred [136743188]

Resulted: 10/09/14 1426, Result status: Final result

Ordering provider:	Ivo Bekavac, MD 10/01/14 1346	Resulted by:	John I Halloran, MD
Performed:	- 10/01/14 1500	Resulting lab:	UPH ALLEN MEMORIAL SUNQUEST RAD
Narrative:			

Allen Memorial Hospital
MCGREW,WILLIAM M
1532 HAWTHORNE ST
WATERLOO, IA 50702

General X-ray
Order No:14ARA24244
PT. LOC:
ADMIT HX:

PHONE: [redacted]
ADMITTING DR: BEKAVAC,IVO MD DOB: [redacted]
ORDERING DR: BEKAVAC,IVO MD FIN#: 562501743
ATTENDING DR:
CC: THIS COPY TO DR.
MEDICAL RECORD NUMBER: 92371812 DOCUMENT STATUS: Final
Exam Date:10/01/2014
PROCEDURE(S):
OUTSIDE FILMS FOR REVIEW
OR READING

REASON FOR EXAM:visual disturbance reading of outside films

CONSULTATION/REVIEW OF OUTSIDE FILMS:

I have been consulted to review a CT angiogram performed on William McGrew at ADI on August 18, 2014. The examination was reviewed on a 3-D physician workstation. Volume rendered and maximum intensity projection images were generated and reviewed

FINDINGS:
Aortic arch: Type II aortic arch. Minimal calcific atherosclerosis aortic arch. Minimal atherosclerosis in origin of the left common carotid artery without a hemodynamically significant narrowing. Origin of the right innominate and left subclavian arteries widely patent.

Right carotid: Small focus of calcific atherosclerosis at the origin of ICA producing a 32% diameter stenosis. The post bulbar cervical ICA is widely patent.

The minimal right ICA diameter measures 3.2 cm. Post bulbar normal ICA diameter measures 4.7 cm

Left carotid: Heterogeneous atherosclerosis of the carotid bulb producing 22% maximal lumen diameter stenosis of the proximal ICA. The post bulbar cervical ICA is widely patent. Circumferential noncalcified moderate stenosis of origin of ECA.

The minimal left ICA diameter measures 4.2 mm. Post bulbar normal ICA lumen diameter measures 5.4 cm.

Vertebrals: Short segmental heterogeneous atherosclerotic plaque producing near occlusive narrowing of the distal right vertebral artery and focal noncalcific moderate stenosis of the distal left vertebral artery.

dso

Signed by: John I Halloran MD on 10/9/2014 2:23 PM
Report created with Powerscribe 360

ALLEN MEMORIAL HOSPITAL, WATERLOO IA. PAGE 2 of 2
MCGREW,WILLIAM M
OUTSIDE FILMS FOR REVIEW DOCUMENT STATUS: Final

Specimen Collection

Type	Source	Collected On
		10/01/14 1500

Radiology Results (10/09/14 - 10/01/14) (continued)

Xray consultation referred [136743188] (continued) Resulted: 10/09/14 1426, Result status: Final result

MRI Lumbar spine wo contrast [136743186] Resulted: 10/01/14 1459, Result status: Final result

Ordering provider:	Ivo Bekavac, MD 10/01/14 1303	Resulted by:	John I Halloran, MD
Performed:	- 10/01/14 1423	Resulting lab:	UPH ALLEN MEMORIAL SUNQUEST RAD
Narrative:			

Allen Memorial Hospital MRI Department
MCGREW,WILLIAM M Order No:14AMR3576
1532 HAWTHORNE ST PT. LOC:
WATERLOO, IA 50702 ADMIT HX:

PHONE [redacted]
ADMITTING DR: BEKAVAC,IVO MD DOB: [redacted]
ORDERING DR: BEKAVAC,IVO MD FIN#: 562501743
ATTENDING DR:
CC: THIS COPY TO DR.
MEDICAL RECORD NUMBER: 92371812 DOCUMENT STATUS: Final
Exam Date:10/01/2014
PROCEDURE(S):
MR SPINE LUMBAR WO
CONTRAST USUAL

REASON FOR EXAM:low back pain

TECHNIQUE: Multiplanar, multisequence imaging of the lumbar spine performed.

CLINCAL HISTORY: see above REASON FOR EXAM

CORRELATION: None available.

FINDINGS:

L1-2 level: Negative

L2-3 level: Negative

L3-4 level: Slight disc space narrowing. Very broad-based far right lateral disc herniation. Protruding disc fills inferior recess the right neural foramen and closely approximates right L3 nerve. Moderate bilateral degenerative facet arthropathy. Mild spinal canal stenosis.

L4-5 level: Moderate bilateral degenerative facet arthropathy, grade I spondylolisthesis, symmetric disc bulge, moderate disc space narrowing and small endplate osteophytes. Mild spinal canal and bilateral neural foraminal stenosis.

L5-S1 level: Mild bilateral degenerative facet arthropathy.

IMPRESSION:
1. L3-4 level far right lateral disc herniation, mild spinal canal stenosis and moderate bilateral degenerative facet arthropathy.
2. L4-5 level degenerative facet arthropathy, spondylolisthesis, and mild spinal canal and bilateral neural foraminal stenosis.

Signed by: John I Halloran MD on 10/1/2014 2:56 PM
Report created with Powerscribe 360

ALLEN MEMORIAL HOSPITAL, WATERLOO IA. PAGE 2 of 2
MCGREW,WILLIAM M
MR SPINE LUMBAR WO CONTR DOCUMENT STATUS: Final

Specimen Collection

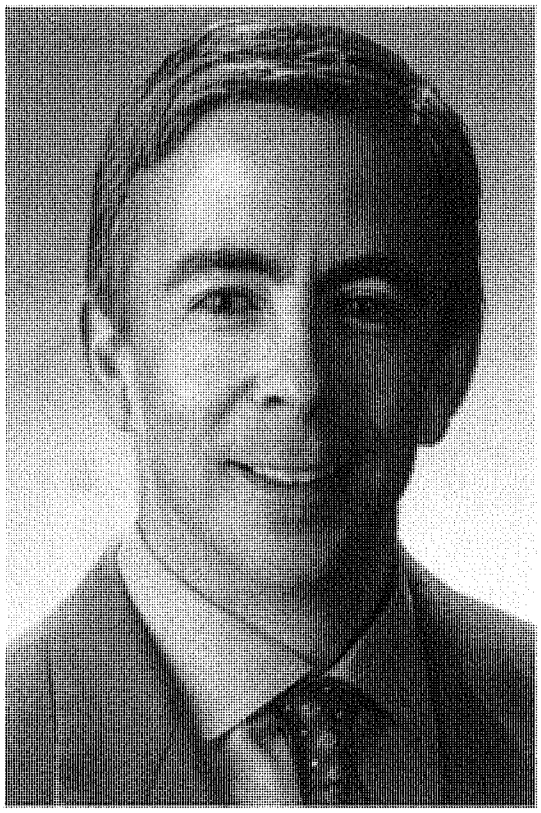
Type	Source	Collected On
		10/01/14 1423

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
49 - WLARAD	UPH ALLEN MEMORIAL SUNQUEST RAD	Unknown	Waterloo IA	10/13/13 1803 - Present

PLAINTIFFS' EXHIBIT 13

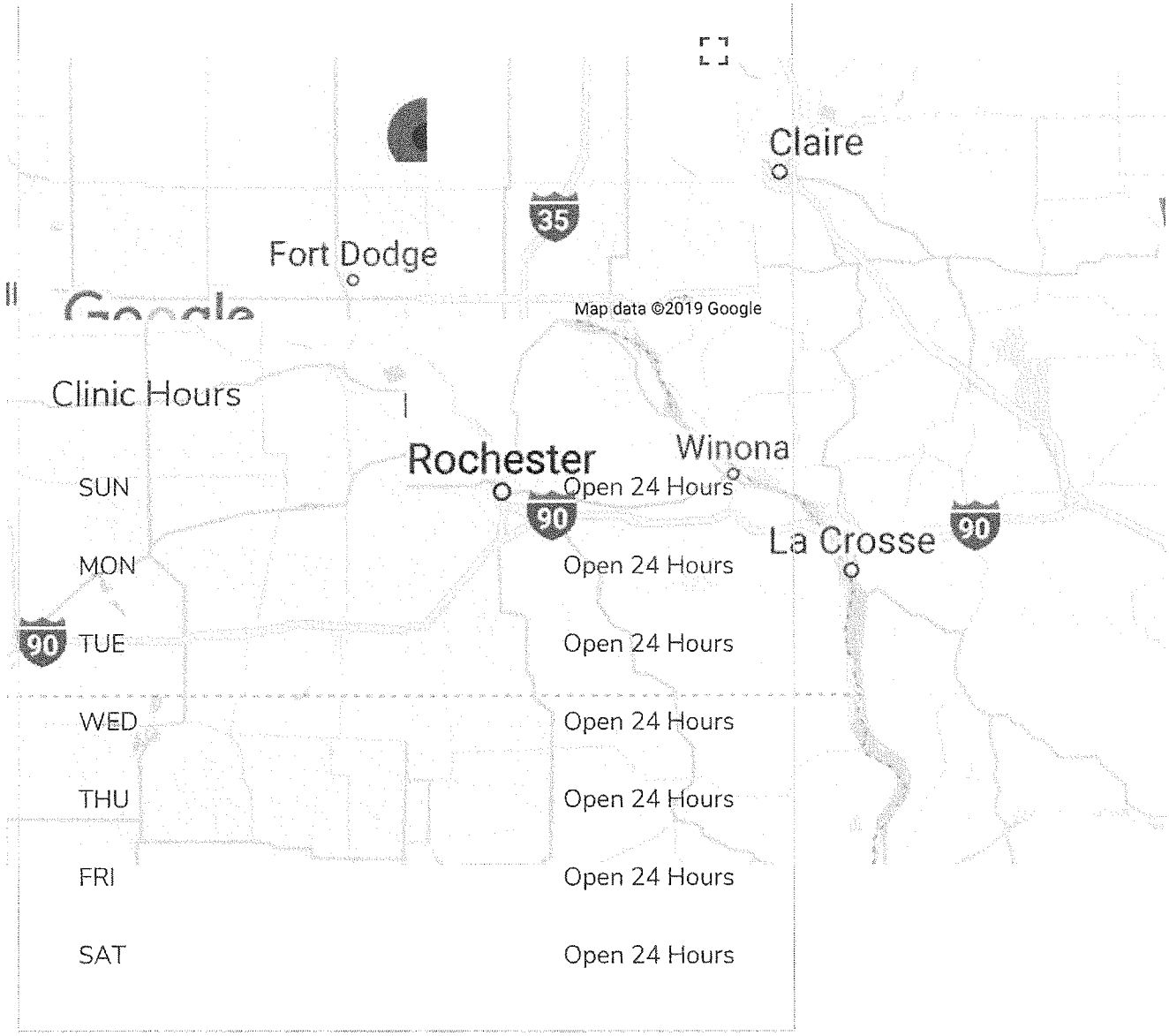
John Halloran, M.D.



1825 Logan Avenue
Waterloo, Iowa 50703

319-235-3941

UnityPoint Health - Allen Hospital



Professional Summary

Specialty

Radiology and Imaging

Areas of Interest

Radiology

Accepts Children

Yes

PLAINTIFFS' EXHIBIT 13A

College/Medical School

University of Minnesota School of Medicine

Residency

University of Iowa Hospitals and Clinics

Board Certification(s):

American Board of Radiology

Fellowship(s):

University of Iowa Hospitals and Clinics

IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW Plaintiffs, v. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D. Defendant.	)	Case No. LACV130355 **AFFIDAVIT OF LISA KNIPP**

STATE OF IOWA)
)
COUNTY OF BUCHANAN)

My name is Lisa Knipp. I live in Fairbank, Iowa. I am the daughter of Bill McGrew. After my father suffered a stroke at Allen Memorial Hospital on September 3, 2014, our family talked about getting a second opinion regarding dad's condition to see whether his condition would be permanent and whether there were things that we could do for him that would improve his condition and lifestyle. We got a recommendation for Dr. Ivo Bekavac, a local Neurologist who practices at 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa.

We made an appointment for September 26, 2014 and I oversaw gathering up all the medical records that I could get regarding my dad's condition including whatever imaging studies I could get my hands on before the visit. I accompanied my dad to the visit.

PLAINTIFFS' EXHIBIT 101

At the visit, we discussed with Dr. Bekavac the history of how my dad had gotten his stroke and the problems that my father was having. During the visit, Dr. Bekavac showed us the CT Angiogram performed on my dad before his surgery. He explained to us that the amount of narrowing in dad's right carotid artery visible on the CT angiogram was not the amount claimed in any of the medical records. My recollection is that the records said something around 65 to 70% narrowing and Dr. Bekavac told us that it was more like 35% narrowing. He also shared with us that he would have the CT angiogram looked at by another physician to confirm his reading of the CT angiogram. Although, based on what he had told us, it was obvious that the CT angiogram had been read incorrectly, Dr. Bekavac told us just that and went on to say that 40% narrowing of my dad's artery was not enough to perform surgery on him. We were very surprised and disappointed to hear that information.

At the end of the visit, we discussed additional care that I do not specifically recall at this time, but which can be found in his progress note. I do recall we discussed a follow-up visit.

At some time later, we learned that the other physician we now know to be Dr. Halloran confirmed Dr. Bekavac's reading. We then received a copy of Dr. Bekavac's progress notes and read through them. It was consistent with what he had told us. Dr. Bekavac has continued to be my father's neurologist to this day.

I certify under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding is true and correct.

Dated: 12-31-18

Lisa Knipp

Lisa Knipp

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, Plaintiffs, vs. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D., Defendants	)	NO. LACV130355 PLAINTIFF WILLIAM MCGREW'S ANSWERS TO INTERROGATORIES PROPOUNDED BY DEFENDANT OTOADESE

COMES NOW Plaintiff William McGrew and hereby submits his Answers to Interrogatories propounded by Defendant Otoadese in the above case.

Martin A. Diaz 000009676
ICIS AT0002000
1570 Shady Ct NW
Swisher, IA 52338
319-339-4350
319-339-4426 fax
marty@martindiazlawfirm.com
Attorney for Plaintiffs

I certify under penalty of perjury that the following Answers to Interrogatories are true to the best of my knowledge.

Dated: 10-28-16

William McGrew

Copy: Counsel of Record

16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

(a) The educational and occupational background of the expert;

(b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;

(c) The subject matter or area on which each expert will testify;

(d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;

(e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also requires that for an expert retained in anticipation of litigation or for trial the expert shall SIGN the answer. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW Plaintiffs, v. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D. Defendant.	)	Case No. LACV130355 **PLAINTIFFS' DESIGNATION OF EXPERTS**

COME NOW the Plaintiffs and hereby designate the following persons who may be called as expert witnesses at the time of trial in the above referenced matter:

1. Dr. Carl Warren Adams
   101 Becket Lake Dr. @ Celadon
   Durango, CO 81301-8853

Dr. Adams is a Board Certified Cardiovascular and Thoracic Surgeon including Trauma and Surgical Critical Care. Dr. Adams will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Adams' education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which is being provided to counsel.

2. Dr. Ivo Bekavac
1735 W. Ridgeway Ave., Suite 112
Waterloo, Iowa 50701

Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Bekavac's education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which has been provided to counsel.

3. Dr. John Halloran
1825 Logan Ave.
Waterloo, Iowa 50701

Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

A professional summary of Dr. Halloran's education, training, experience, and qualifications to testify as an expert witness can be found at the website for UnityPoint Health: www.unitypoint.org/waterloo. A CV may be provided later.

4. Kent Jayne
502 Augusta Circle
North Liberty, Iowa 52317

Mr. Jayne is a Certified Life Care Planner, vocational rehabilitation specialist and an economist who has been asked to develop a life care plan for Bill McGrew and can then testify to the amount of money needed to fund that life care plan. Depending on how the court rules on the issue of a lien for medical expenses, he may be asked to determine what medical bills are related to the injuries and damages sustained by Bill McGrew due to the negligence of the defendants.

Mr. Jayne's education, training, experience, and qualifications are as set forth in his curriculum vitae, which is being provided to counsel.

The following witnesses are "experts" in that they have scientific, technical or other specialized knowledge. However, these individuals (like Dr. Bekavac and Dr. Halloran) have not been retained in anticipation of litigation, and their expert opinions, if any, have not been developed in anticipation of litigation, but rather arise from the fact that these individuals may be treating physicians to the Plaintiff or have such other connection to this litigation that they are fact witnesses with specialized expertise.

5. All of Bill McGrew's treating health care providers as disclosed in the

discovery process. This includes all individuals disclosed in depositions including the defendants.

6. All other providers of services, assistive devices, educational care, custodial care and rehabilitative care as disclosed in the discovery process.

7. Plaintiffs reserve the right to call any other treating health care provider to testify to Bill McGrew's health history and potentially to causation and damages.

8. Plaintiff reserves the right to utilize, as experts, those individuals designated by the defendants in their designation to the Court.

9. Plaintiff reserves the right to call any rebuttal expert witnesses to any expert witness designated by defendants that raise issues otherwise not anticipated or expected.

Respectfully submitted,

MARK L. CHIPOKAS PC

By: /s/ Mark L. Chipokas
Mark L. Chipokas, AT0001418
866 First Avenue NE
P.O. Box 1261
Cedar Rapids, Iowa 52406-1261
(319) 366-7888
(888) 466-1350 Fax
E-mail: mark@mlchipokaspc.com

/s/ Martin A. Diaz
Martin A. Diaz 000009676
1570 Shady Ct NW
Swisher, IA 52338
phone 319 339 4350
facsimile 319 339 4426
marty@martindiazlawfirm.com
Attorneys for Plaintiffs

Copy to all counsel via EDMS

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,** **Defendants**	)	**NO. LACV130355** **PLAINTIFF WILLIAM MCGREW'S SUPPLEMENTAL ANSWER TO INTERROGATORY NO. 16 PROPOUNDED BY DEFENDANT OTOADESE (Retained Experts)**

COMES NOW Plaintiff William McGrew and hereby submits his Supplemental Answer to Interrogatory No. 16 propounded by Defendant Otoadese in the above case.

/s/ Martin A. Diaz
Martin A. Diaz 000009676
ICIS AT0002000
1570 Shady Ct NW
Swisher, IA 52338
319-339-4350
319-339-4426 fax
marty@martindiazlawfirm.com
Attorney for Plaintiffs

Copy: Counsel of Record on March 7, 2018 (with report of Dr. Adams sent on March 8, 2018)

16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

(a) The educational and occupational background of the expert;

(b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;

(c) The subject matter or area on which each expert will testify;

(d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;

(e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also requires that for an expert retained in anticipation of litigation or for trial the expert shall SIGN the answer. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(b)

Dr. Carl Warren Adams
101 Becket Lake Dr. @ Celadon
Durango, CO 81301-8853

(a) Please refer to his CV previously produced.

(b) Please refer to the list of cases previously provided

(c) Dr. Adams is a Board Certified Cardiovascular and Thoracic Surgeon including Trauma and Surgical Critical Care. Dr. Adams will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

(d) Attached is the report from Dr. Adams.

(e) Dr. Adams is generally ready to be deposed. However, he will be given the opportunity to read the deposition of Dr. Otoadese and Dr. Cammoun, if taken, before he is deposed.

Kent Jayne
502 Augusta Circle
North Liberty, Iowa 52317

(a) Please refer to his CV previously produced.

(b) Please refer to the list of cases previously provided

(c) Mr. Jayne is a Certified Life Care Planner, vocational rehabilitation specialist and an economist who has been asked to develop a life care plan for Bill McGrew and can then testify to the amount of money needed to fund that life care plan. Depending on how the court rules on the issue of a lien for medical expenses, he may be asked to determine what medical bills are related to the injuries and damages sustained by Bill McGrew due to the negligence of the defendants.

(d) Attached is the report from Mr. Jayne. Please also see the "Handicapped Accessibility Updates to Home" provided by Magee Construction Company which was provided to Mr. Jayne after he prepared his report.

(e) Mr. Jayne is prepared to be deposed. However, he may be review additional information as Mr. McGrew's condition is permanent and he requires constant care.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,** **Defendants**	)	**NO. LACV130355** **PLAINTIFF WILLIAM MCGREW'S SUPPLEMENTAL ANSWER TO INTERROGATORY NO. 16 PROPOUNDED BY DEFENDANT OTOADESE (Treating Physicians)**

COMES NOW Plaintiff William McGrew and hereby submits his Supplemental Answer to Interrogatory No. 9 propounded by Defendant Otoadese in the above case.

/s/ Martin A. Diaz
Martin A. Diaz 000009676
ICIS AT0002000
1570 Shady Ct NW
Swisher, IA 52338
319-339-4350
319-339-4426 fax
marty@martindiazlawfirm.com
Attorney for Plaintiffs

Copy: Counsel of Record on March 7, 2018

16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

(a) The educational and occupational background of the expert;

(b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;

(c) The subject matter or area on which each expert will testify;

(d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;

(e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also requires that for an expert retained in anticipation of litigation or for trial the expert shall SIGN the answer. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(c)

Dr. John Musgrave, Dr. Matthew Smith, Dr. Richard Mauer, Dr. Ivo Bekavac, and Dr. John Halloran may testify pursuant to previously produced medical records and Plaintiff's Designation of Experts, filed February 6, 2018.

Dr. Bekavac will testify as to the standard of care, causation, and permanency. In his medical record dated September 26, 2014, Dr. Bekavac reviewed the CTA and determined a stenosis of the right ICA of approximately 40%. 40% stenosis is not sufficient to justify endarterectomy. The first and therefore the second endarterectomy were unnecessary and violated the standard of care. Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Halloran, in his medical record dated October 9, 2014, reviewed the CTA and assessed a stenosis of 32%. Dr. Cammoun and Dr. Otoadese misread the CTA and

violated the applicable standard of care. Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Musgrave may be asked to testify about Bill McGrew's medical history before and after his stroke and his care and treatment of Bill McGrew.

Dr. Maurer may be asked to testify about his care and treatment of Bill McGrew.

Dr. Smith has provided handwritten responses to questions propounded by Kent Jayne and those responses are part of the report prepared by Mr. Jayne. In addition, Dr. Smith may be asked to testify to his care and treatment of Bill McGrew.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, Plaintiffs, vs. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D., Defendants	)	NO. LACV130355 PLAINTIFF WILLIAM MCGREW'S SUPPLEMENTAL ANSWERS TO INTERROGATORIES PROPOUNDED BY DEFENDANT OTOADESE

COMES NOW Plaintiff William McGrew, by counsel, and hereby submits his Supplemental Answers to Interrogatories propounded by Defendant Otoadese in the above case.

/s Martin A. Diaz

Martin A. Diaz 000009676
ICIS AT0002000
1570 Shady Ct NW
Swisher, IA 52338
319-339-4350
319-339-4426 fax
marty@martindiazlawfirm.com
Attorney for Plaintiffs

Copy: Counsel of Record sent by email on December 18, 2018.

(a) Yes. Plaintiff began to receive Medicare when he turned age 65. His Medicare claim number is [redacted] but he also has a United Healthcare AARP number for insurance (ID # is [redacted]).

(b) N/A

(c) N/A

(d) N/A

(e) N/A

(f) Yes, but it has not yet produced a printout.

SUPPLEMENTAL ANSWER:

(f) Please refer to the most recent printout provided to counsel.

25. State with particularity the basis of your liability claim against these Defendants. Identify with specificity each and every negligent act (fault) and the name and address of each witness who will support the claim.

ANSWER:

Plaintiffs refer the defense to the Petition. Plaintiffs may supplement after taking the depositions of facts witnesses and disclosures of experts.

SUPPLEMENTAL ANSWER:

Please refer to the medical records from Allen Memorial Hospital, the records from Drs. Bekavac and Halloran, the expert disclosures and the deposition of Dr. Adams. The specifications of negligence are as follows:

Regarding Dr. Cammoun:

1. Failing to correctly interpret the amount of stenosis in the right internal carotid artery.

Regarding Dr. Otoadese:

1. Performing a right carotid endarterectomy on September 2, 2014 on an asymptomatic patient;
2. Failing to correctly interpret the amount of stenosis in the right internal

carotid artery;
3. Failing to investigate the length of time that the patient had signs or symptoms of a stroke on September 3, 2014; and
4. Failing to take Mr. McGrew promptly back to surgery after he learned that Mr. McGrew was having signs or symptoms of a stroke on September 3, 2014.

Marty Diaz

From: George Weilein <GWeilein@wbpclaw.com>
Sent: Monday, November 26, 2018 8:54 AM
To: Marty Diaz; JER@ShuttleworthLaw.com
Cc: mark@mlchipokaspc.com; Barb Helmlinger; JMILLER@ShuttleworthLaw.com
Subject: Re: McGrew v. Cammoun--defense expert depositions

I join in Jennifer's e-mail on behalf of Dr. Cammoun.

George
>>> Jennifer Rinden <JER@ShuttleworthLaw.com> 11/25/2018 5:18 PM >>>
Marty -

Sorry for the delayed response - I have been out of the office on other matters. I was the one who initially requested the depositions of Drs. Halloran and Bekavac. Upon further reflection, I do not believe these depositions are necessary. Neither of these doctors have expressed standard of care opinions and will not be allowed to do so given the fact we have not been provided a written report from either. Further, Halloran is not even a treater, let alone a retained expert, and I intend to file a motion in limine to exclude any reference to him as completely irrelevant to these proceedings.

As for your request for our experts, I have asked Barb to check with Drs. Levett and Gebel to see what might work. I have two trials in December and another 2 week trial in January. By necessity, these depositions will be toward the end of January at the earliest. As you know, the first word I had of your interest in these depositions was November 14. We will do what we can to get these scheduled but given the timing of the request and my schedule, the options will be limited. George will respond concerning the availability of his expert.

Thanks - Jennifer

Sent from my iPad

On Nov 20, 2018, at 10:48 AM, Marty Diaz <Marty@martindiazlawfirm.com<mailto:Marty@martindiazlawfirm.com>> wrote:

[EXTERNAL EMAIL]
I understand that you are both busy, but I would like to confirm the deposition date and time for Drs. Halloran and Bekavac, and would like to schedule in the depositions of your experts. Please see my email below.

Thanks.

Marty

Martin A. Diaz
1570 Shady Ct NW
Swisher, IA 52338
(319) 339-4350
Fax: (319) 339-4426
marty@martindiazlawfirm.com<mailto:marty@martindiazlawfirm.com>

From: Marty Diaz <Marty@martindiazlawfirm.com<mailto:Marty@martindiazlawfirm.com>>
Sent: Wednesday, November 14, 2018 7:33 AM
To: Mark Chipokas <mark@mlchipokaspc.com<mailto:mark@mlchipokaspc.com>>; George Weilein <GWeilein@wbpclaw.com<mailto:GWeilein@wbpclaw.com>>

PLAINTIFFS' EXHIBIT 202

Cc: JER@ShuttleworthLaw.com<mailto:JER@ShuttleworthLaw.com>;
JMILLER@ShuttleworthLaw.com<mailto:JMILLER@ShuttleworthLaw.com>; Marty Diaz
<Marty@martindiazlawfirm.com<mailto:Marty@martindiazlawfirm.com>>
Subject: RE: McGrew v. Cammoun--defense expert depositions

Jennifer and George-

Now that we have scheduled the depositions of our remaining experts for January 21 or 22, I would like to schedule the depositions of all defense experts. I want to take Dr. Hawk in person in California, so please provide dates when you are both available. I would imagine that no more than 1.5 hours for Dr. Hawk should be enough.

I also want to take Dr. Levett's deposition in person in Cedar Rapids. If we take the depositions of Drs. Halloran and Bekavac on either January 21 or 22, we can take the deposition of Dr. Levett on the other date. I will need no more than 1.5 hours for him.

I am willing to take Dr. Gebel's deposition by videoconference. I will need no more than 1.5 hours for him.

Please let me know what dates work for both of you for all these depositions.

Thanks.

Marty

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PLAINTIFFS' EXHIBIT 202

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.** **Defendants**	)	**NO. LACV130355** **PLAINTIFFS' WITNESS LIST, LIST OF EXHIBITS AND DESIGNATION OF DEPOSITION PORTIONS**

COMES NOW the Plaintiff and advises the court and Defendant of his list of prospective Exhibits for the upcoming trial and requests that Defendant provide designations as to the admissibility of these exhibits:

WITNESS LIST

In addition to the Plaintiffs, the Plaintiffs anticipate calling the following witnesses:

1. Lisa Knipp, daughter of Plaintiffs.
2. Michelle McGrew, daughter of the Plaintiffs.
3. Melanie Bird, daughter of the Plaintiffs.
4. Troy McGrew, son of the Plaintiffs.
5. Linda Morgan, neighbor.
6. Kyle Larson, friend of Bill
7. Dr. Richard Mauer, Opthalmologist
8. Dr. Ivo Bekavac, Neurologist
9. Dr. John Halloran, Neuroradiologist

10. Dr. Carl Adams, Durango, CO

11. Allyson Landphair, ARNP

12. Aubrey Donlea, PCT at Allen Memorial Hospital

13. Rachel Havens, RN at Allen Hospital

14. Dr. Otoadese

15. Kent Jayne, North Liberty

16. Claire Boyle, Social Worker at New Aldaya

Plaintiffs reserve the right to call the following possible witnesses:

1. All persons disclosed during discovery.

2. All rebuttal witness.

3. All foundation witnesses.

4. All witnesses declared by Defendants.

5. Any expert designated by Defendants.

EXHIBIT LIST

EXHIBIT NUMBER	DESCRIPTION OF EXHIBIT	DEFENDANT'S DESIGNATION
1	Dr. Mauer: plan note and ophthalmology chart note for July 25, 2014 for Bill McGrew	
2	Dr. Mauer: request for Ultrasound and addendum with results of Ultrasound	
2A	Ultrasound report of August 6, 2014	
3	Informed Consent for Cataract Surgery for August 20, 2014	
4	Dr. Otoadese: Initial Visit of August 18, 2014	
5	Dr. Cammoun: report of CT angiogram of August 18, 2014	
6	Dr. Mauer: telephone message canceling cataract surgery	
7	Dr. Otoadese: Second visit of August 20, 2014	
8	Operative report of September 2, 2014	
9	Discharge summary for September 2, 2014 admission authored by Ms. Landphair	
10	Dr. Otoadese: encounter note for October 2, 2014	
11	Dr. Bekavac: progress note for September 26, 2014	
11A	Dr. Bekavac: CV	
12	Dr. Bekavac: progress note for October 30, 2014	
13	Dr. Halloran: imaging reports for October 1, 2014	
13A	Dr. Halloran: Resume or qualifications	
14	September 2, 2014 surgery timeline	
15	Nurse Borrett: significant event note for September 3, 2014 at 7:20 AM	
16	Select Nursing flowsheets for September 3, 2014	
17	Dr. Almullahassani: Consultation notes in September 2014	
18	Operative report of September 3, 2014	
19A	Reports: CT and MRI of Head between 849am and 932am on September 3, 2014	
19B	Reports: CT Angiogram at 1245pm on September 3, 2014	
19C	Reports: MR Angiogram and MRI Brain at 1031am on September 4, 2014	

20	Dr. Manshadi: Consultation report of September 5, 2014	
21	Gastroenterology Notes and Operative report for Endoscopy on September 8, 2014	
22	Dr. Almullahassani: Consultation report of January 26, 2015	
23	Dr. Smith: Progress note of September 21, 2018	
24	Dr. Bekavac: all other progress notes and relevant records	
25	Diagram prepared by Dr. Cammoun	
25A	Diagram prepared by Dr. Otoadese	
26	Dr. Otoadese: other relevant medical records	
27	Dr. Musgrave: progress notes for 8-27-14 and 9-30-14	
28	Dr. Inamdar: consultation report of November 6, 2014	
29	Mayo Clinic: select records	
30	New Aldaya: select records	
31-34	Photos before his injuries	
35	Photos taken Friday before surgery and day of surgery	
36	Photo of McGrew Home exterior	
37	Photo of McGrew backyard	
38	Photo of McGrew garage	
39	Photos at McGrew Home Interior	
39A-B	Photos of golf at Beaver Hills on 8.29.14	
40	Report of Kent Jayne	
40A	Kent Jayne: Report from Dr. Smith	
40B	Kent Jayne: CV	
41	Dr. Adams: CV	
42-50	Reserved for other exhibits and demonstrative aids. This includes a calendar (July to October 2014) and possible medical illustrations.	

AMENDED DESIGNATION OF DEPOSITION PORTIONS

Pursuant to IRCP 1.704(2), Plaintiffs will designate 5 separate portions from the deposition of Dr. Otoadese. The first will be shown by videotape to the jury and relates to Dr. Otoadese's qualifications. The remaining 4 portions will be read into the record in the presence of the jury throughout the trial and deal with different aspects of the medical care and treatment of Mr. McGrew. Pursuant to Iowa Rule 1.705(1), Defendant is requested to offer any other part of the deposition "relevant to the portion offered." Plaintiffs request that any additional portions be provided at least 10 days before trial so that any video editing can be performed. If not provided by then, Plaintiff will only show that portion of the video designated and will read into the record any other relevant portion.

DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #1 (By Video) ---Qualifications	**Page 4, L. 11**	**Page 4, L. 25**
	Page 5, L. 1	**Page 5, L. 25**
	Page 6, L. 1	**Page 6, L.25**
	Page 7, L. 1	**Page 7, L. 25**
	Page 8, L. 1	**Page 8, L. 25**
	Page 9, L. 1	**Page 9, L. 4**
	Page 10, L. 15	**Page 10, L. 21**
	Page 11, L. 21	**Page 11, L. 25**
	Page 12, L. 1	**Page 12, L. 25**
	Page 13, L. 1	**Page 13, L. 25**
	Page 14, L. 1	**Page 14, L. 25**
	Page 15, L. 1	**Page 15, L. 25**
	Page 16, L. 1	**Page 16, L. 25**

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	Page 18, L. 1	Page 18, L. 25
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	Page 20, L. 1	Page 20, L. 25
	Page 21, L. 1	Page 21, L. 25
	Page 22, L. 1	Page 22, L. 15
	Page 23, L. 8	Page 23, L. 25
	Page 24, L. 1	Page 24, L. 18

DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #2 (Read)--- Events of September 3, 2014	Page 37, L. 25	--
	Page 38, L. 1	Page 38, L. 24
	Page 39, L. 8	Page 39, L. 25
	Page 40, L. 1	Page 40, L. 25
	Page 41, L. 1	Page 41, L.25
	Page 42, L. 1	Page 42, L.13
	Page 42, L. 23	Page 42, L. 25
	Page 43, L. 1	Page 43, L.25
	Page 44, L. 1	Page 44, L.25
	Page 45, L. 1	Page 45, L. 25
	Page 46, L. 1	Page 46, L.9
	Page 47, L. 14	Page 47, L.25
	Page 48, L. 1	Page 48, L. 25
	Page 49, L. 1	Page 49, L.3

DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #3 (Read)--- August 18, 2014 Visit	Page 58, L. 9	Page 58, L.25

	Page 59, L. 1	Page 59, L. 25
	Page 60, L. 1	Page 60, L.25
	Page 61, L. 1	Page 61, L.3
	Page 63, L. 4	Page 63, L. 25
	Page 64, L. 1	Page 64, L. 16

DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #4 (Read)--- Ultrasound	Page 66, L. 17	Page 66, L.25
	Page 67, L. 1	Page 67, L.25
	Page 68, L. 1	Page 68, L.23
	Page 70, L. 21	Page 70, L. 25
	Page 71, L. 1	Page 71, L. 25
	Page 72, L. 1	Page 72, L. 25
	Page 73, L. 1	Page 73, L. 3

DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #5 (Read)--- Informed Consent	Page 95, L. 3	Page 95, L.25
	Page 96, L. 1	Page 96, L.25
	Page 97, L.1	Page 97, L.16
	Page 98, L. 7	Page 98, L. 25
	Page 99, L.1	Page 99, L.22
	Page 99, L. 24	Page 99, L.25
	Page 100, L. 1	Page 100, L.3

Respectfully submitted,

/s/ Martin A. Diaz
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Attorney for Plaintiff

MARK L. CHIPOKAS PC

By: /s/ Mark L. Chipokas
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E-mail: mark@mlchipokaspc.com

copy:
Per EDMS

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, Plaintiffs, vs. EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.D., and DRISS CAMMOUN, M.D., Defendants.	NO. LACV130355 Videotaped Deposition of EROMOSELE OTOADESE, M.D.

Videotaped Deposition of EROMOSELE OTOADESE, M.D., taken before Julie M. Kluber, Certified Shorthand Reporter, commencing at 9:32 a.m., March 8, 2018, at 515 Main Street, Suite E, Cedar Falls, Iowa.

Julie M. Kluber, CSR, RMR
3515 Lochwood Drive NE
Cedar Rapids, IA 52402
319-286-1717
1-866-412-4766

PLAINTIFFS' EXCERPT #1

APPEARANCES

Plaintiffs by:	MARTIN A. DIAZ Attorney at Law 1570 Shady Court NW Swisher, IA 52338 and MARK L. CHIPOKAS Attorney at Law 866 First Avenue NE P.O. Box 1261 Cedar Rapids, IA 52406-1261
Defendants Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic by:	JENNIFER E. RINDEN VINCENT S. GEIS Attorneys at Law 115 Third Street SE, Suite 500 P. O. Box 2107 Cedar Rapids, IA 52406-2107
Defendant Cammoun by:	GEORGE L. WEILEIN Attorney at Law 515 Main Street, Suite E P. O. Box 724 Cedar Falls, IA 50613
Videographer:	Josh Goding

INDEX OF EXAMINATION

INDEX OF EXHIBITS

PROCEEDINGS

THE VIDEOGRAPHER: Good morning. We're on the record at 9:32 a.m., March 8, 2018, at the law offices of Weilein and Boller, P.C., in Cedar Falls, Iowa.

EROMOSELE OTOADESE, M.D., called as a witness, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DIAZ:

Q. Doctor, could you please introduce yourself by providing us with your full name.
A. Anthony Eromosele Otoadese.
Q. All right. And I understand you like to go by Dr. Tony?
A. Yes.
Q. Okay. Doctor, in front of you is a document marked Exhibit 1, which is -- my understanding is this is your c.v. that was provided to us. Can you look at it and let me know if this is up to date.
A. Yes, it is.
Q. Okay. My understanding is you were born in Nigeria?
A. Yes.

Q. And what year did you come to the United States?
A. 1971.
Q. And for what purpose did you come to the U.S.?
A. To study.
Q. And what did you want to study when you first came in 1971?
A. I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry.
Q. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978.
A. Yes.
Q. And a chemistry major?
A. Chemistry, yes.
Q. Okay. And then the next thing that I have on your c.v. is that you then went to medical school at the State University of New York Downstate in Brooklyn and got your medical degree in 1987.
A. Yes.
Q. Okay. Your c.v. doesn't tell us what you did between 1978 and 1987. Can you tell us what you did?

A. I did -- Yeah, I did -- I did graduate work in biochemistry.
Q. So you were a student, then, the entire time or --
A. Yes.
Q. -- only part of that time?
A. No. I was a student the whole time.
Q. So when you came to the United States in 1971, did you come to go to college or -- or was it high school or what was that?
A. I finished high school in Costa Mesa in California, then went to college.
Q. Okay. So pretty much from when you came to the U.S. in 1971 up until 1987, when you start medical school, you are -- you're a student. Correct?
A. Yes. Graduate student, yes.
Q. Right. Both high school, undergrad, graduate, and now you're going to go to medical school.
A. Medical school, yes.
Q. Okay. And then you're in medical school up until 1987, and then from there you do your residency, your fellowship -- I'm sorry, your internship, your residency, and then fellowships that take you all the way up to

1996. Correct?
A. Yes. Correct.
Q. So essentially you're a student from 1971 up until 1996.
A. Yes.
Q. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics.
A. Yes, I did.
Q. Okay. Now, have you done any additional education other than what we see up through 1996?
A. As far as -- you mean college education or -- or specialty training? I don't understand what the question is.
Q. Sure. So your c.v. takes us all the way up to 1996, and my understanding is that you start working, then, in Waterloo in around 1996?
A. Yes. I finished -- This is the only job I ever had. I finished, I took a job here, and I've been here since then.
Q. Okay. And what I'm interested in knowing is in addition to what you already have on your c.v., is there any additional medical education or training that you've had since 1996?

8

A. Over the years, yes. I -- You know, I got into interventional vascular surgery and I took training in this.
Q. So what's interventional vascular work? What is that?
A. Interventional endovascular procedures, using balloons and stents to supplement, to complement the open surgeries that I do.
Q. Okay. So up through 1996 in terms of your training, was your training limited to open type procedures?
A. Open, yes.
Q. And did you start learning endovascular work?
A. After that.
Q. After that.
A. Right.
Q. Okay. And do you list that anywhere on your c.v.?
A. No, you don't -- I don't need to. Just -- It's just not -- I didn't get diplomas or anything from it, so --
Q. Or certificates?
A. No certificates, no.
Q. Well, when you --
A. They're meetings. You go to meetings. Some of

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them a week, some of them two weeks. Hands-on experience and things, yeah.
Q. Okay. And --
A. I did that.

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Q. My understanding is that practically all of your hospital work is at Allen Memorial Hospital. Is that right?
A. Yes, yes.
Q. I think at one time you said it was 99 percent of your work?
A. Yeah. I would say that, yeah.

Q. Okay. And my understanding that once you finished your training at University Hospitals and went into private practice, you came to Waterloo and you -- you were with one particular -- I want to call it a clinic. I

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don't know what you would -- what you called it back then, but there were -- it was you and a couple of other colleagues that ran a -- a clinic. What was the name of that clinic?
A. I'm trying to remember. Cardiac Surgery Associates or something like that, yes.
Q. Right. And then at some point Cardiac Surgery Associates merges with Cedar Valley Medical Specialists, Professional Corporation. Correct?
A. Right. It wasn't a merger, but -- but we -- we joined them. We -- we were asked to join them because the cardiologists at the hospital were part of Cedar Valley. We were independent and Dr. John Wiggins, he was the senior partner. He had hired me. He didn't want to join Cedar Valley, he wanted to be independent, but the cardiologists who we work very closely with were part of Cedar Valley, so the hospital administrator said it's -- it's easier and works better if -- when the surgeons and the cardiologists are in the same group. So we were made to join them politically, and that's one reason John left.
Q. Okay. And then my understanding is you were at

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Cedar Valley Medical Specialists from 1999 until 2012 -- through 2012.
A. Yes.
Q. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was -- what was the relationship within that organization?
A. Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly, when you first joined you're not a shareholder but after two years or something you become a shareholder.
Q. Okay. I've seen documents from the secretary of state that show that in 2012, the last year that you were there, that there were 58 different physicians that were part of Cedar Valley Medical Specialists.
A. Yes.
Q. Okay. And that they included Dr. Bekavac, Dr. Halloran, Dr. Cammoun --
A. Yes.
Q. -- and you.
A. Yes.
Q. Correct?

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A. Um-hmm. Yes.
Q. And then my understanding is in 2013, you open up Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C.
A. Yes, I did.
Q. Okay. And actually, the records show that you formally created the company in November of 2012. Is that -- is that about right?
A. Yes, yes.
Q. In anticipation that you're going to start January 1 of 2013. Correct?
A. I don't remember the dates. Yes.
Q. And it's true, isn't it, that you were terminated from Cedar Valley Medical Specialists? I think you described it as they kicked you out. Is that correct?
A. Correct, yes.
Q. Okay. Now, I want to talk about the kind of work that you've done since you started in -- started in private practice in roughly 1996. We talked about you doing open procedures.
A. Yes.
Q. And endovascular work.
A. Yes.
Q. So I want to understand the difference. So

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when you talk about open procedures, what are we talking about there?
A. Open surgery where you -- you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you -- it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're able to do them without opening the abdomen. You could do percutaneous, for example. You go through the groin without making incisions and you put a stent in the aneurysm. That's endovascular.
Q. Okay. And my understanding is that you were doing -- as part of the open procedures, you're doing open -- what you call open heart surgery.
A. Yes.
Q. And I know that some folks don't necessarily use that term "open heart" the way that maybe a layperson might understand it. Can you tell us what that would have consisted of, what you -- What will you be doing if you're doing open heart work?

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A. Heart surgery. Valve replacement, coronary artery bypass grafting, aneurysm resection. You open the chest.
Q. Okay. Now, if you -- If somebody were to come to you today and say, "I want to do open heart" -- "I want you to do an open heart surgery," would you be able to do that on them?
A. I could but I don't do them anymore. I stopped doing open heart in 2009.
Q. I think you've testified in the past that you stopped doing open heart surgeries in 2008 and that you --
A. Okay.
Q. -- voluntarily surrendered your privileges to do open heart surgeries.
A. Yes, I did.
Q. Okay. And that my understanding is that that was at the insistence of the hospital. Is that true?
A. No.
Q. That's not true?
A. No.
Q. All right. So it was your desire all along to just stop doing open heart surgeries in 2008, 2009?

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MS. RINDEN: Well, hold on. I'm going to object to the form. Argumentative.
You can answer, Doctor, if you can.
A. Yes. It's -- I -- I don't know if it's something to be discussed here, but it was political, and -- and it even resulted in a lawsuit and was settled out of court, but it wasn't -- it wasn't that straightforward. It was political, yes.
Q. I understand the concept of political, but the -- but the true answer to my question when I said that the hospital insisted that you stop doing them, that -- that is technically true. Correct?
A. Not correct. It's not.
Q. So the hospital didn't ask you to stop doing open heart surgeries?
A. They did not -- they did not ask -- I did not stop doing open heart surgery because they asked you to.
Q. They told you to.
A. It was negotiated.
MS. RINDEN: Hold on a minute. You guys are talking at the same time, and I'm going to object to form. Argumentative. Let him -- let

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him -- you finish your answer and then let him finish, Marty.
A. If you insist that I go into it, it was a political thing, and -- and I wasn't -- I wasn't in agreement with -- with -- with things and I sued the hospital, and that resulted in a lot other things. All I can tell you is that I am still in good standing in the hospital. I do all my surgeries there. I -- I mean I'm still on the -- on the hospital staff in good standing.
Q. Okay. So just to summarize, there was some sort of disagreement between you and the hospital that related to doing open heart surgeries. Your viewpoint is that there was a political decision. Correct?
A. Correct.
Q. It ended up in you filing a lawsuit with some kind of a settlement that's confidential. Correct?
A. Correct.
Q. Okay. All right. The fact is that you've not done open heart surgeries, then, since roughly 2008, 2009. Is that true?
A. 2009, yes.

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Q. Okay. Now, my understanding from looking at things you've said in the past that you were doing in this timeframe of roughly 1999 to 2008 -- I'm going to use that timeframe -- you were doing 50 to 60 percent of all surgeries were open heart surgeries, 30 to 40 percent were vascular surgeries, and 10 to 20 percent was thoracic. Is that true?
A. Noncardiac thoracic.
Q. Okay. So I want to understand what we're talking about. So up until you have this -- this disagreement with the hospital --
A. Yes.
Q. -- 2008, 2009, you're doing about 50 to 60 percent of your work is doing open heart surgeries.
A. I would say so, yes.
Q. Okay. And about 30 to 40 percent is vascular, so what is vascular then?
A. Peripheral vascular, working on arteries and veins.
Q. So in this case with Mr. McGrew where you end up doing a carotid endarterectomy, what is that? Is that a vascular procedure?
A. Vascular.

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Q. Okay. And then 10 to 20 percent would be noncardiac thoracic.
A. Yes.
Q. Meaning what?
A. Lungs, esophagus, you know, anything in the chest other than heart.
Q. Okay. In this timeframe before you stopped doing the open heart surgeries, when you did vascular work, what percentage of your vascular work was open and what percentage was endovascular?
A. I can't -- I can't guess. I can't -- I can't guess. I think most of it was open. But I can't give you percentage.
Q. In reading what you've testified in the past about, I got the impression that you were far more comfortable doing open procedures than you were doing endovascular. Is that a fair statement?
A. In the -- in the beginning, yes, because the open was what I was trained doing.
Q. Right.
A. But I'd say learned more endovascular and got better in it, and I'm just as comfortable doing endovascular now.

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Q. Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time?
MS. RINDEN: I'm going to object to the form. You can go ahead and answer, Doctor.
A. Yes. I would say until -- again, I can't put numbers in it, but all I can tell you that I was the only cardiovascular surgeon in the Cedar Valley up until 2008 or so, so I did all the open heart surgeries. I did most of the vascular surgeries and most of the thoracic surgeries.
Q. Are you able to give me a reasonable estimate of the number of surgeries you would do in a year back then?
A. At one point I was doing over 1,000.
Q. Okay. All right. So if you're losing 50 to 60 percent of your open heart work, does that mean 500 to 600 of those surgeries were lost, meaning you're no longer doing them, or is it not that simple?
A. It's not that simple.
Q. Okay.

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A. Because we were doing them about 300 -- 300 -- two-eighty to 300 hearts, open hearts a year.
Q. They just take longer.
A. Yes.
Q. And so for that reason, 50 percent, 60 percent of your time may be a more appropriate way rather than saying 50, 60 percent of your surgeries.
A. Well, yeah. Yes, I agree with that.
Q. Okay. All right. Now, you have testified in the past that despite your being fired from Cedar Valley Medical Specialists in 2012 that you maintained, quote, "a good working relationship with those folks."
A. Yes.
Q. Okay. But -- and I don't want to be unfair to you, Doctor.
A. Okay.
Q. I used the word "fired" as the equivalent of "terminated." You used the word -- This is what you said. You said, "They terminated me. They kicked me out."
A. That's what I'm saying. I'm just clarifying that.
Q. And I appreciate that. I appreciate that. Did you have any -- for example, did you get along with Dr. Bekavac?
A. Yes. I still do, yes.
Q. Okay. Do you get along with Dr. Halloran?
A. Yes. I still do.
Q. Okay. Is there anyone at Cedar Valley with whom you did not have a good working relationship when you left in 2012?

A. Working relationship, no. I get along with everybody.
Q. Okay. All right. As you sit here, I know you're aware that Dr. Bekavac has written -- he's got a medical record that talks about his viewpoint of what happened with Mr. McGrew. I assume you've had a chance to look at that?
A. Yes, I have.
Q. Okay. And I assume you've seen Dr. Halloran's interpretation of the CT angiogram done on Mr. McGrew on August 18th of 2014?
A. Yes, I have.
Q. I assume you disagree with both of them.
A. Yes, I do.
Q. Okay. Do you have an explanation for why they've taken the position that they've taken?
A. No, I can't -- I can't second-guess them. I don't -- you know.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D.; and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.,** **Defendants**	)	**NO. LACV130355** **DEFENDANTS' OBJECTIONS TO PLAINTIFFS' DEPOSITION DESIGNATIONS**

Defendants Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. provide the following objections to Plaintiffs' depositions designations:

Part 1: All designated testimony from pages 11:21—24:18.

In the Deposition at page 11:21 and through 24:18, the subjects generally include background information pre-dating this case, including the circumstances under which Dr. Otoadese left a prior professional clinic (Cedar Valley Specialists) which involved a lawsuit, settlement, and issues of liability insurance; circumstances under which Dr. Otoadese stopped doing open heart surgery (a type of surgery that is not at issue in this case) at Allen Hospital which involved a lawsuit, settlement, and privileging issues; Plaintiffs' speculative theory that Dr. Otoadese was financially motivated to recommend surgery to Mr. McGrew; a suggestion that Dr. Otoadese is not "comfortable" doing endovascular surgery; Dr. Otoadese's working relationship with Dr. Bekavac and Dr. Halloran -- intended to bolster the credibility of those physicians in the eyes of the jury; and seeking speculative testimony as to why Dr. Bekavac and Dr. Halloran would disagree with Dr. Otoadese.

These subjects and this deposition testimony should be excluded. They are completely irrelevant and non-probative to the issues the jury will decide, are unsupported by Plaintiffs' expert as in anyway connected to the alleged medical negligence, and would be incurably prejudicial to Dr. Otoadese. They are collateral issues that would waste the Court and jury's time and create suspicions, doubts, and potential hostilities towards Dr. Otoadese. Further, the only way Defendants could adequately respond to the evidence would only compound the prejudice. Even if minimally probative (which Defendants do not concede), the likelihood of unfair prejudice far exceeds the probative value of these subjects.

This evidence should be excluded under Rules 5.402, 5.403, 5.408, 5.411, Defendants' Motion in Limine ¶4 (b) (c) (e) (g); ¶5 (lawsuits), ¶6 (privileging), ¶9 (insurance), ¶12 (settlement); Plaintiff's First Motion in Limine ¶4 (other litigation); Plaintiffs' Second Motion in Limine ¶8 (opinions about credibility of others).

In addition there is inadmissible hearsay in these pages. See Rule 5.802. Hearsay in these sections includes: the conduct of Cedar Valley Specialists of terminating, firing, or "kicking Dr. Otoadese out" (14:13-17, 23:11-16) and Allen Hospital's alleged "insistence" that Dr. Otoadese give up his privileges for open heart surgery or that it "told" him to (16:17-19, 17:11-21).

Part 2:

Line 41:7-17: Rule 5. 802 (hearsay)

Line 42:23-43:9 (through "I said no."): Hearsay (5.802); speculation

Line 44:9-45:10: Hearsay and related to hearsay

Part 3: All testimony designated in lines 58:9 through 64:16.

Deposition 58:9-60:6 is related to the recommendation of an "open" surgery or stenting. This is not relevant to any issue the jury will decide. There are no expert criticisms of Dr.

Otoadese recommending an open procedure. This is only offered to either suggest a financial motive or that Dr. Otoadese is somehow not as qualified as he should be. *See* Rule 5. 402, 5.403; Defendants' motion in limine ¶4(e).

Deposition 63:4-64:16 relates to dictation and documentation practices. No expert opines on these issues as in anyway remotely related to anything. They are not. Rules 5.402, 5.403.

Part 4: All testimony designated 66:17 through 73:3.

This testimony concerns Dr. Otoadese not ordering a second ultrasound, implying it was because of lack of reimbursement for Dr. Otoadese's own lab. 66:17-68:23. Plaintiffs' expert does not opine there should have been a repeat ultrasound. Dr. Otoadese testified he did not need one given he ordered a CT angiogram. This subject has no relevance and is only designated to suggest financial concerns controlled Dr. Otoadese's decisions. It is wishful thinking, speculation and fabrication. *See* Rule 5.402, 5.403, Defendants' motion in limine ¶4(e)

At Deposition 70:21-72:3, Plaintiffs' counsel asked questions about ultrasound interpretation to which Dr. Otoadese put no weight and did not know how its values were created. Plaintiffs' counsel proceeds to testify about "a society for ultrasound techs that put together sort of values . . .". Whatever Plaintiffs seek to accomplish, it is not relevant. Plaintiffs' expert Dr. Adams does not offer any criticism of Dr. Otoadese based upon the ultrasound. *See* Rules 5.402, 5. 403. It is also in the form of a hypothetical with no basis in fact and is inadmissible on this basis as well. *See Hubby v. State*, 331 N.W.2d 690, 696 (Iowa 1983) ("The facts assumed in a hypothetical question must be supported by the evidence in the record.").[1]

[1] "It is well established in this jurisdiction, as well as elsewhere, that where the record is lacking in any evidence proving or tending to prove the assumed facts, the hypothetical question is improper." *State v. Tharp,* 138 N.W.2d 78, 83 (Iowa 1965); *id.* at 84 (finding improper hypothetical that was not supported by the evidence was prejudicial, could not be cured by an instruction, and required reversal; "where there was no evidence to support the question, we think the properly objected-to opinion created such prejudicial testimony that it could not be erased by such an instruction to disregard. The poison could not be thus neutralized.").

Part 5: Lines 99:22-100:3.

In this testimony, Dr. Otoadese was asked if he told Dr. McGrew about a 20% risk of not doing surgery. But this is *not* Plaintiffs' informed consent claim. Instead, Plaintiffs' informed consent claim--assuming without conceding it is admissible--is that Dr. Otoadese did not give information as an alternative medication therapy assuming surgery was necessary. See Rules 5. 402, 5.403.

II. General Objections.

a. Plaintiffs should not be allowed to introduce Dr. Otoadese's deposition and also call him as a witness in their case.

Plaintiffs list Dr. Otoadese as a trial witness but it is unclear if they are calling him live or by deposition. Defendants object if Plaintiffs intend to call Dr. Otoadese in their case in chief in addition to showing/reading portions of his deposition. Plaintiffs should only be allowed one or the other: call Dr. Otoadese as a witness or show/read those portions of his depositions allowed by the Court—not both.

For witnesses who are available in court to testify and who will testify in court, showing or reading deposition testimony serves to emphasize that testimony. It is likely to also include repetitive testimony—further emphasizing it. A live witness may not testify repeatedly. The opportunity for repetition and emphasis does not exist for live witnesses or witnesses for whom there is no deposition. Deposition testimony should be treated no differently than a live trial witness—the jury should hear from the witness once in the party's case.

As to the portion of the deposition Plaintiffs intend to show by video, it is even more important that it be shown once and not repeated by live testimony. "Videotaped testimony may seem more believable or important to the lay jury because it can both see and hear the witness. .

. . Repeatedly showing the same few deposition segments seems to exalt the relevance of those videotaped shreds of evidence over live testimony.*" Hynix Semiconductor Inc. v. Rambus Inc.*, 2008 WL 190990 * 1 (N.D. Cal. Jan. 21, 2008); *see also Bannister v. Town of Noble*, 812 F.2d 1265, 1269 (10th Cir. 1987) (acknowledging "dominating nature of film evidence" as a "legitimate concern;" discussing concern that jury will give greater weight to film).

b. Plaintiffs should not be allowed to show or read deposition excerpts in segments "throughout trial" but the allowed portions of the deposition should be shown and read in one setting.

Plaintiffs designate portions of Dr. Otoadese's deposition in five separate sections and suggest the sections will be shown and read "into the record . . . throughout the trial." Defendants object to showing and reading the deposition in isolated segments. All portions of Dr. Otoadese's deposition that is allowed over defense objections should be shown/read in one setting.

A party may not call a live witness to testify repeatedly—picking and choosing subjects to cover in isolated segments "throughout trial." Nor should Plaintiffs be allowed to do this via a deposition. Allowing Plaintiffs to use deposition testimony in selected excerpts "throughout the trial" will serve to give that testimony undue emphasis and increase the likelihood it will be taken out of context from the witnesses' entire testimony. Such segments will be separated in time from the remainder of the witness' testimony and any cross examination. Rule 5.106 provides that when a party introduces part of a statement, the adverse party may require introduction "at that time" of any other part "that in fairness ought to be considered at the same time." Plaintiffs should be required to show or read whatever portions of Dr. Otoadese's deposition is allowed in one setting to avoid undue emphasis and unfair prejudice.

c. Using deposition excerpts during voir dire or during opening statements.

Defendants object to any use of deposition excerpts during voir dire or opening statements. Such use would be unfairly prejudicial to Defendants, emphasizing the testimony by means of mere repetition. A live witness may not testify repeatedly. Depositions should be treated no differently. *See Wyatt Technology Corp. v. Malvern Instruments, Inc.*, 2010 WL 11505684 *22 (C.D. Cal., 2010) (precluding use of videotaped depositions in opening statements as the "lay jury would put undue weight on that testimony" given it may be shown multiple times "in the exact same form."); *Id* ("[O]pening arguments is not the time to play excerpts of video-taped depositions."); *see also In re C.R. Bard, Inc., Pelvic Repair Sys. Prod. Liab. Litig.*, 2013 WL 3282926 *8 (S.D.W. Va. 2013) (subsequent history on other matters omitted) (precluding the parties from using video deposition clips during opening statements).

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CERTIFICATE OF SERVICE
The undersigned hereby certifies that a copy of this document was served upon counsel of record for each party to the action in compliance with the applicable IRCP February 15, 2019, by:

[x] Electronically via EDMS for registrants
[ ] U.S. Mail
[ ] Fax
[ ] Overnight Courier
[ ] Hand Delivery
[x] E-mail Judge Stigler (JER)

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IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D.; and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.** **Defendants**	)	**NO. LACV130355** **PLAINTIFFS' RESISTANCE TO OBJECTIONS TO DEPOSITION DESIGNATIONS**

COME NOW the Plaintiffs and in resistance to the Objections filed by Defendants to Plaintiffs' Deposition Designations state:

Part 1: This excerpt relates to Dr. Otoadese's qualifications as a physician and surgeon.[1] Defendants have already filed a motion in limine relating to this issue and plaintiffs have filed a resistance to that motion. For the court's convenience, plaintiffs will restate that argument and then provide additional comments to the objections filed:

Dr. Otoadese has testified that in 2008-2009 he "voluntarily" surrendered his hospital privileges to perform heart surgery, which at the time constituted 50-60% of his overall time performing surgeries. Dr. Otoadese then filed suit against Allen

[1] It is noteworthy that Defendants have marked Dr. Otoadese's CV as proposed Exhibit K.

Memorial Hospital relating to these surrendered privileges and reached a confidential settlement unknown to these Plaintiffs. (*See Otoadese v. Allen Memorial Hospital*, Black Hawk County, LACV114625). But, notwithstanding that settlement, Dr. Otoadese has not performed "open heart" surgeries since 2009. He has admitted that at the time he was performing "open heart" surgeries, they constituted 50-60% of his surgery time and approximately 30% of his overall surgeries.

In 2012, Dr. Otoadese was "kicked out" (terminated)[2] from Cedar Valley Medical Specialists and on January 1, 2013 he opened Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. In the summer of 2014, Dr. Otoadese's surgeries were limited to vascular and nonvascular thoracic areas of the body and he was still not performing open-heart procedures---consistent with the fact that he no longer had privileges to perform open heart surgeries.

One of Dr. Otoadese's experts is Dr. James Levett, a cardio thoracic surgeon from Cedar Rapids. Dr. Levett was retained as an expert witness by Allen Hospital in the lawsuit filed by Dr. Otoadese. Dr. Levett was hired to testify to the

[2] These are Dr. Otoadese's words. He explains in his deposition that he was terminated because CVMS was not able to get insurance to cover his practice. Plaintiffs do not know if that is an accurate reflection of why, but they do not intend to offer that evidence unless the defendant wishes to.

appropriateness of the decision to withhold surgical privileges from Dr. Otoadese to perform open-heart procedures.

The above facts are undisputed.

It is also undisputed that on August 18, 2014, Mr. McGrew went to see Dr. Otoadese who recommended surgery and did not discuss with Mr. McGrew alternative treatment for his condition that did not require surgery.

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.

Iowa Rule of Evidence 5.702

Iowa law existing at the time this case was filed, Iowa Code §147.139, provided as follows:

> If the standard of care given by a physician….is at issue, the court shall only allow a person to qualify as an expert witness and to testify on the issue of the appropriate standard of care if the person's medical…qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case.

Dr. Otoadese will testify in his own defense. Dr. Otoadese is an expert witness and he will testify to the fact that he did not violate the standard of care. In order to assess Dr. Otoadese's credibility as an expert, the court must provide the plaintiff the opportunity to question Dr. Otoadese's qualifications including any limitations on his hospital privileges, and the successes and failures that he has had as a physician and surgeon. This includes any motivation that he may have had to

perform surgery on Mr. McGrew. The evidence will include the fact that his surgical practice had taken a substantial downturn in 2009 when he was not allowed to perform open-heart procedures. The evidence will also include the fact that his surgical practice was significantly affected by his termination ("kicked out", as he termed it) from Cedar Valley Medical Specialists. In order to properly assess Dr. Otoadese's skill as a physician and his motive for recommending surgery, the jury needs to be given all relevant information. Failure to provide the jury with that information would mislead the jury.

If Dr. Otoadese were called as a retained expert, plaintiffs would be permitted to inquire about the hospital privileges maintained by him and whether he had ever been terminated from a clinical group. That information would be relevant to assess his qualifications to render standard of care opinions.

In addition to the undisputed facts regarding his hospital privileges at Allen Memorial Hospital, and his termination from Cedar Valley Medical Specialists, there is the additional evidence that one of Dr. Otoadese's expert witnesses has previously testified as an expert witness against Dr. Otoadese in the case involving his privileges to perform open-heart procedures at Allen Memorial Hospital.

This inquiry into the qualifications of any expert, including a defendant who was an expert, has been recognized by the Iowa Supreme Court:

> We are committed to a liberal rule on admissibility of expert testimony, *Wick v. Henderson*, 485 N.W.2d 645, 648 (Iowa 1992), and the admission of

such testimony rests within the sound discretion of the district court. *Tappe v. Iowa Methodist Medical Ctr.*, 477 N.W.2d 396, 402 (Iowa 1991). Iowa Rule of Evidence 702 has "codified Iowa's existing liberal rule on the admission of opinion testimony." *Hutchison v. American Family Mut. Ins. Co.*, 514 N.W.2d 882, 885 (Iowa 1994). The United States Supreme Court reaffirmed this approach in *Daubert v. Merrell Dow Pharmaceuticals*, *Inc.*, 509 U.S. 579, 125 L. Ed. 2d 469, 113 S. Ct. 2786, 2799, 125 L. Ed. 2d 469, 485 (1993). Rule 702 provides:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.

Further, in its comments to rule 702, the advisory committee stated:

> *If* [pursuant to Iowa Rule of Evidence 104(a)] *the Court is satisfied that the threshold requirements have been met, the witness should be allowed to testify.* **All further inquiry regarding the extent of his [or her] qualifications go to the weight that the fact finder can give such testimony under Rule 104(e).**

Carolan v. Hill, 553 N.W.2d 882, 888 (Iowa 1996) (Italics in original; bold added)

In *Hutchison v. American Family Mut. Ins. Co*., 514 N.W.2d 882 (Iowa 1994), the plaintiff objected to testimony from defendant's retained expert because he was not board certified in neuropsychology and because he was a psychologist and not a medical doctor testifying about medical causation. In rejecting this objection, the court took pains to point out that the ultimate assessment of qualifications was left to the trial process including cross-examination and jury assessment of the witness. The court stated:

> Dr. Moore has board certification as a clinical psychologist, holds a Ph.D. in clinical psychology, and has substantial experience in neuropsychology. Although Dr. Moore lacked board certification in neuropsychology, we believe this fact went to the weight of his testimony, not its admissibility.
>
> ***
>
> Although few of these restrictions on experts strike us as fundamentally unsound, we refuse to impose barriers to expert testimony other than the basic requirements of Iowa rule of evidence 702 and those described by the Supreme Court in *Daubert.* The criteria for qualifications under rule 702--knowledge, skill, experience, training, or education--are too broad to allow distinctions based on whether or not a proposed expert belongs to a particular profession or has a particular degree.
>
> ***
>
> We understand the concern that expert testimony regarding the causes of personal injury can fall "wholly in the realm of conjecture, speculation, and surmise." Nevertheless, we agree with the *Daubert* Court that the trial court in its discretion and the jury in its deliberation provide the most effective determination of the admissibility and weight of expert psychological testimony.
>
> ***
>
> Similarly, we believe with the aid of vigorous cross examination, the jury is fully capable of detecting the most plausible explanation of events. ….
>
> ***
>
> Moreover, plaintiffs had ample opportunity to discredit Dr. Moore. Plaintiffs' counsel subjected Dr. Moore to *thorough cross examination regarding his qualifications* and the basis of his testimony, *placing special emphasis on his lack of medical qualifications*. …

Id. at 886-889 (Italics added)

Finally, in *Andersen v. Khanna*, 913 N.W.2d 526 (Iowa 2018), the Court held that the personal characteristics of a physician may establish a duty of disclosure as part of obtaining informed consent for treatment. In discussing the duty to disclose surgical experience, the Court noted the following:

> Indeed, at trial several experts testified regarding the number of Bentall procedures they had performed and their training to perform the procedure in

> order to establish their competency to testify as expert witnesses. *It stands to reason that if such information is relevant to establishing a witness's expertise, such information could be material to a reasonable patient's decision to or not to undergo a particular treatment.*

Id. at 540 (emphasis added).

The Court cited with approval a Louisiana Court of Appeals decision that "held the physician had a duty to disclose his chronic alcohol abuse." *Andersen* at 542 (citing to *Hidding v. Williams*, 578 So. 2d 1192, 1196 (La. Ct. App. 1991)). The Court makes clear that the qualifications of a physician may be relevant to consent, and in the process highlights that a physician's history is important in assessing their credibility.

Defendants contend that permitting evidence of the qualifications of the defendant physician would be more prejudicial than probative. However, it would be more prejudicial not to tell the jury about the qualifications and working history of this physician. Under what circumstances is the qualifications of an expert physician not probative? Under what circumstances is the working history of an expert physician not probative? They clearly are. If prejudice exists, it does so because defendant's qualifications create such prejudice. It is not prejudice created by the plaintiffs. If any such prejudice exists, it cannot outweigh the probative value of a jury understanding a physician's qualifications.

Additional comments:

1. In their Objections, Defendants make the following statement: "the circumstances under which Dr. Otoadese left a prior professional clinic (Cedar Valley Specialists) *which involved a lawsuit, settlement, and issues of liability insurance*." (Objections, p.1)

Plaintiffs are not aware of any lawsuit or settlement arising out of the termination of Dr. Otoadese from the practice at Cedar Valley Medical Specialists. While Dr. Otoadese claimed that the reason he was "kicked out" was because he was uninsurable, plaintiffs do not intend to show that part of his answer.

2. Defendants contend that the use of the word "termination" or "kicked out" are hearsay. Both terms have been used by Dr. Otoadese in a prior deposition and are therefore his words and not the words of a third party. He endorsed those terms in this deposition. His own words are not hearsay but rather are admissions. The same applies to any description of his disagreement with Allen Hospital. He responded to questions regarding how one would interpret the decision to have him stop performing cardiac surgery.

3. While plaintiffs do not intend to go into other lawsuits filed against Dr. Otoadese including any pending lawsuits, they do seek to discuss the lawsuit that Dr. Otoadese filed because it was filed in response to losing his privileges. It also establishes that notwithstanding any confidential settlement he has not performed

open heart surgeries which constitute 50 to 60% of the work time that he performed at that time. It is part and parcel of his qualifications and his practice. The jury is entitled to know all aspects of his qualifications, not just those that the defendant wishes to disclose. To only disclose what the defendant wishes to disclose would mislead this jury.

Part 2:

Pages 41-43: In these sections, Dr. Otoadese is describing a series of events related to post-stroke care of Mr. McGrew. He is also describing a conversation he had with Dr. Hassani about whether Mr. McGrew should be taken back to surgery. This is Dr. Otoadese describing the event and uses the conversations that he had with Dr. Hassani to explain the events. This is not hearsay. It is not being offered for the truth of the matter asserted. Rather, it is offered to describe the progression of events that took place. There is also no speculation as Dr. Otoadese has firsthand knowledge of the events.

***Pages 44-45*:** The same analysis applies to this conversation. Again, it is not offered for the truth of the matter asserted but rather offered to explain the progression of events that took place and Dr. Otoadese's decision-making and conduct.

Part 3: Plaintiffs anticipate that Dr. Otoadese will testify that he obtained informed consent to the procedure. He has indicated that as part of that consent he

disclosed to Mr. McGrew and his daughter all the treatment options. These questions relate to that subject matter and are clearly related to the case. Further, one of the factual disputes is what information was provided by Mr. McGrew and documented in the medical chart. How Dr. Otoadese dictates and what parts are information that he obtained and what parts are information that some other person in his office obtain and documented is relevant to the jury's determination of what occurred on August 18, 2014. These questions elicit how the documentation was prepared.

Part 4: There will be conflicting testimony as to the significance of the carotid ultrasound done on August 6, 2014. One of defendants' experts contends that the carotid ultrasound was abnormal, while others contend that it was normal. For example, Dr. Mauer will testify that he ordered the carotid ultrasound and he relied upon it in determining what recommendations to make to Mr. McGrew. On the other hand, Dr. Otoadese testified that he put literally no weight on the ultrasound. He claims that the ultrasound cannot be relied upon because it was performed at an outside facility. Plaintiffs inquired whether he could have performed his own ultrasound at his own facility, and he responded as set forth in this section. This information is relevant and exclusion of it would be error.

Part 5: As noted in response to Defendants' motion in limine, plaintiffs claim that Dr. Otoadese did not obtain adequate informed consent. Defendants

have an idea of what they think is informed consent; plaintiffs have their own viewpoint. This includes not only what he told them but also what he didn't tell them. Iowa case law focuses on what a patient would want to know. While expert testimony is needed in order to understand the treatment options and risks and benefits of a procedure, it is not the only evidence available to establish such a claim. There will be significant disagreement between the parties as to whether surgery was necessary and to the extent that surgery would be appropriate whether the patient was properly advised about the risks of the surgery. One of the issues that a jury can consider is whether the risk of not doing surgery is as important as knowing the risk of doing surgery. In order to assess that claim, the jury needs to have this information. This is simply part of the information that he needs to know.

II. General Objections:

a. IRCP 1.704 permits a party to use a deposition of a party "for any purpose".

Defendants seek to prevent plaintiffs from reading or showing portions of the deposition of Dr. Otoadese while also calling him as a live witness**.** At this time, plaintiffs only intend to offer his deposition testimony, but do not want to be limited in also calling him as a witness. Defendants cite to no rule or other authority that would prohibit them from doing so.

IRCP 1.704 states:

> Any part of a deposition, so far as admissible under the rules of evidence, may be used upon the trial…. against any party who appeared when it was taken… to do any of the following:
> (2) For any purpose if, when it was taken, deponent was a party adverse to the offeror…

IRCP 1.705(1) further provides "[I]f a party offers only part of a deposition, any other party may require an offer of all of the deposition relevant to the portion offered, the deposition…."

The rules recognize that a party may choose to show or read to the jury any part of a deposition of another party so long as the other party is given an opportunity to designate other parts relevant to the portion that is being offered. Such an offer was made in this case and defendants have so designated. The rules anticipate that a party may do so without having to read the entire deposition and may do so in a piecemeal fashion. In other words, that there may be more than one excerpt to be shown or read.

There is no rule that prohibits reading parts of an opposing party's previous testimony and also calling the individual as an adverse witness. Given the fact that a party opponent's deposition is essentially an admission, it is reasonable that one could read parts of the deposition to establish admissions and then call the individual as an adverse witness. In fact, you can do it in a serial fashion.

b. IRCP 1.704 and 1.705 permit a party to show or read excerpts from a party opponent's deposition throughout the trial.

As noted above, the rules anticipate that one would read excerpts from a party opponent's deposition throughout the trial. IRCP 1.705 allows a party to designate parts of a deposition so long as other parts relevant to the part to be read are also included. Defendants do not cite to any authority for the position that it is taking. There is nothing that prohibits a party from reading in different segments throughout the trial. IRCP 1.704 permits any part of a party opponent's deposition to be read "for any purpose." In this case, plaintiffs can read the deposition of Dr. Otoadese at different times of the trial because it will be "for any purpose" that it believes will aid in their presentation of their case.

c. Plaintiffs do not intend to show or read deposition excerpts during voir dire or opening statements.

However, plaintiffs are not precluded from otherwise using any admissions during opening statements.

Respectfully submitted,

/s/ Martin A. Diaz
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Attorney for Plaintiffs

copy: Per EDMS

IN THE IOWA DISTRICT COURT IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE, MCGREW	)	**Law No. LACV130355**
Plaintiff,	)	
	)	
vs.	)	**JURY INSTRUCTIONS**
	)	
EROMOSELE OTOADESE, M.D., and NORTHERN IOWA CARIOVASCULAR AND THORACIC SURGERY CLINIC P.C.	)	
Defendants	)	

Members of the Jury.

This trial arises out of medical treatment involving William McGrew as the patient and Dr. Otoadese as the physician. The McGrews allege that Dr. Otoadese was negligent in his care and treatment of William McGrew and as a result of this alleged negligence, William McGrew and Elaine McGrew were damaged.

Dr. Otoadese denies that he was negligent, denies causing damage to William McGrew and Elaine McGrew or denies the extent of the damages to William McGrew or Elaine McGrew, if any.

Do not consider this summary as proof of any claim. Decide the facts from the evidence and apply the law which I will now give you.

INSTRUCTION NO. 6

The fact that a party is a corporation should not affect your decision. All persons are equal before the law, and corporations, whether large or small, are entitled to the same fair and conscientious consideration by you as any other party.

Defendants, Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. are to be treated as a single party for the purposes of these instructions. When I refer to Dr. Otoadese in these instructions, I am also referring to Defendant Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C.

INSTRUCTION NO. 9

William and Elaine McGrew claim that Dr. Otoadese was negligent. In order to prevail on this claim, William McGrew must prove all of the following propositions:

1. Dr. Otoadese was negligent by failing to meet the standard of care in performing an unnecessary surgery on William McGrew's right carotid artery on September 2, 2014

2. Dr. Otoadese's negligence, if any, was a cause of damage to William McGrew.

3. The amount of damage.

If William McGrew has proved each of these propositions, he is entitled to damages in some amount. If William McGrew has failed to prove any of these propositions, then you are to consider his claim for inadequate informed consent in Instruction No. 13.

FILED

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

19 MAR -7 PM 1:36

CLERK OF DISTRICT COURT
BLACK HAWK COUNTY, IOWA

WILLIAM MCGREW and ELAINE MCGREW	)	
	)	
Plaintiff,	)	**Law No. LACV130355**
	)	
vs.	)	**ORDER OF JUDGMENT**
	)	
EROMOSELE OTOADESE, M.D., and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC PC	)	
Defendant.	)	

This matter came before the Court for jury trial on February 26 through March 5, 2019. A jury verdict form appropriately signed by the presiding juror was duly received by the Court on March 5, 2019. A copy of the verdict form is attached to this Order.

Judgment is hereby accordingly entered in favor of the Defendants, Eromosele Otoadese, M.D., and Northern Iowa Cardiovascular and Thoracic Surgery Clinic PC. The costs of this matter are assessed to the Plaintiff. Counsel may file any additional necessary pleading as concerns the costs of this matter.

By prior order of the Court all exhibits entered in this matter shall have a security level of 2 as said exhibits may contain personal, confidential or unredacted information. An Exhibit Management Order will be entered as a separate document reflecting this security level.

Signed on 3/7/2019.

BY THE COURT:

KELLYANN M. LEKAR, JUDGE

Copies to:
Counsel of record

IN THE IOWA DISTRICT COURT IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,	)	**Law No. LACV130355**
Plaintiff,	)	
	)	
vs.	)	**VERDICT FORM**
	)	
EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC P.C.	)	
Defendant.	)	

We find the following verdict on the questions submitted to us:

Question No. 1: Was Dr. Otoadese negligent in his decision to perform surgery on William McGrew on September 2, 2014?

Answer "yes" or "no."

ANSWER: No

[If your answer is "yes", then proceed to Question No. 2. If your answer is "no," then go to Question No. 3.]

Question No. 2: Was the negligence of Dr. Otoadese a cause of damage to William McGrew?

Answer "yes" or "no."

ANSWER: _____

[If your answer is "yes", then proceed to Question No. 5. If your answer is "no," then go to Question No. 3.]

Question No. 3: Was Dr. Otoadese negligent in obtaining informed consent from William McGrew?

Answer "yes" or "no."

ANSWER: No

[If your answer is "yes", then proceed to Question No. 4. If your answer is "no," then do not answer further questions.]

Question No. 4: Was the negligence of Dr. Otoadese a cause of damage to William McGrew?

Answer "yes" or "no."

ANSWER: _____

[If your answer is "yes", then proceed to Question No. 5. If your answer is "no," then do not answer further questions.]

DAMAGES

Answer Question Nos. 5 and 6 only if you answered "yes" to Question Nos. 2 or 4.

Question No. 5: State the amount of damages sustained by William McGrew for each of the following items of damage. If William McGrew has failed to prove any item of damage, enter 0 for that item.

1. Future Life Care Expenses $_____
2. Past Loss of Full Mind and Body $_____
3. Future Loss of Full Mind and Body $_____
4. Past Pain and Suffering $_____
5. Future Pain and Suffering $_____

TOTAL (add the separate items of damage) $_____

[Go to Question No. 6]

Question No. 6: State the amount of damages sustained by Elaine McGrew for each of the following items of damage. If Elaine McGrew has failed to prove any item of damage, enter 0 for that item.

1. Past Loss of Consortium $_____

2. Future Loss of Consortium $_____

TOTAL (add the separate items of damage) $_____

Taylor Brown

PRESIDING JUROR*

*To be signed only if verdict is unanimous.

_____

Juror **

_____

Juror**

_____

Juror**

_____

Juror**

_____

Juror**

_____

Juror**

_____

Juror**

****To be signed by the jurors agreeing to it after six hours or more of deliberation.**

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D.; and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.,** **Defendants**	)	**NO. LACV130355** **DEFENDANTS' RESISTANCE TO PLAINTIFFS' SUPPLEMENTAL MOTION FOR NEW TRIAL** **WITH AUTHORITIES**

Defendants Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. (collectively "Dr. Otoadese") resist Plaintiffs' Supplemental Motion for New Trial ("Supplemental Motion") and Plaintiffs' Supplement to their Supplemental Motion and state: [1]

1. Plaintiffs present the issue in their Supplemental Motion as one subject to the Court's discretion. *See* Supplemental Motion at 4.

2. It is well within the Court's discretion to find there was no "misconduct" or "irregularity" and that Plaintiffs were not prejudiced. *See* Rule 1.1004. Plaintiffs are not entitled to a new trial.

3. Dr. Otoadese does not agree or concede that Plaintiffs' Supplemental Motion for New Trial is timely. The judgment (with the verdict) was filed March 7, 2019 and Plaintiffs filed their Supplemental Motion on April 22, 2019 without a motion for leave to do so or a

[1] Defendants refer herein to documents attached to Plaintiffs' Supplemental Motion, including:
- Defendant's Answers to Plaintiff's Interrogatory No. 7, served Dec. 7, 2016 ("Interrogatory Answer")
- Iowa Board of Medicine Press Release and Statement of Charges and Settlement Agreement (Combined), approved by the Board April 12, 2019 ("Board's Order")

motion for extension of time. *See* Rule 1.1007 (motion for new trial must be filed within 15 days after filing the verdict unless an extension of no more than 30 days is granted). Without waiving this argument, Dr. Otoadese addresses the merits of Plaintiffs' Supplemental Motion below.

WHEREFORE for the reasons set forth above and below, Dr. Otoadese requests that Plaintiffs' Supplemental Motion for New Trial be denied.

ARGUMENT

I. The Iowa Board of Medicine information upon which Plaintiffs rely does not include or represent an admission of incompetence and only became available after trial.

There are two threshold issues which defeat Plaintiffs' Supplemental Motion: 1) the Iowa Board of Medicine ("Board") information does *not* represent an admission by Dr. Otoadese that he was negligent or incompetent, and 2) the information upon which Plaintiffs rely became available *after* trial was concluded in this matter.

A. There was no admission or finding of incompetence or negligence.

Plaintiffs' Supplemental Motion is based at least in part upon the assumption that Dr. Otoadese has admitted he was negligent or incompetent. *See* Supplemental Motion at 3 ("His [settlement] agreement constitutes an admission of professional incompetence."); Plaintiffs' Supplement to Supplemental Motion, filed April 29, 2019, at 1 (arguing Dr. Otoadese may have testified untruthfully given he "admitted to the Iowa Board of Medicine that he was professionally incompetent in treating [Mr. McGrew]"). Plaintiffs are mistaken.

The Board's Order is a Combined Statement of Charges and Settlement Agreement. It expressly states that it "constitutes the resolution of a contested case proceeding." Board's

Order at 5 ¶13. There was no finding by the Board of professional incompetence or admission by Dr. Otoadese.

An examining board's statement of charges is just that—charges. Charges prove nothing. In *McClure v. Walgreen Co.*, 613 N.W.2d 225 (Iowa 2000), the Iowa Supreme Court held that a statement of charges and settlement documents (in which a pharmacy agreed to be on probation) were inadmissible in a civil case involving the pharmacy. *Id.* at 235-37. The Court held:

> The statement of charges was irrelevant because it was merely assertions of wrongdoing. None of the matters in the statement of charges was either proved or disproved.
>
> . . .
>
> Because the statement of charges and the stipulation and consent order were irrelevant and therefore inadmissible, we do not reach the balancing questions under rule 403.

Id. at 236-37 (but noting that "tone of the charges conveys an atmosphere of criminality").[2] In *McClure*, the statement of charges concerned the very same incident that was the subject of the litigation. *Id.* at 234. The Court still found the charges irrelevant. *See also id.* at 236 (finding board evidence "*proved nothing*") (emphasis added); *In re Ziegler*, 2006 WL 623685 *3 (Iowa Ct. App. 2006) ("a theft charge is not tantamount to a theft conviction. It is an accusation, not an act. While evidence of the latter is admissible to attack a party's credibility, evidence of the former is not.")

Not only is a statement of charges irrelevant, as reflecting "mere[] assertions of wrongdoing," the settlement agreement also proves nothing and is not an admission. The *McClure* Court found that nothing in the settlement with the licensing board "amounted to an *admission* of wrongdoing." 613 N.W.2d at 236 (emphasis in original). Instead, the settlement

[2] The *McClure* Court reversed a judgment on punitive damages and remanded on that issue given the improperly admitted evidence. *Id.* at 237.

was "'motivated by a desire for peace *rather than from a concession of the merits*.'" *Id.* (emphasis added) (quoting Am. Jur. 2nd).

In this case, Dr. Otoadese and the Board resolved the dispute represented by the Board's charges. There was no hearing. There was no finding or admission of professional negligence or incompetence. There was a settlement. *See* Board Order at 1 (citing Iowa Code §272C.3(4) which provides licensing boards have authority to settle a matter with a licensee). Plaintiffs cannot unilaterally convert a settlement of disputed charges into an adverse finding or an admission of incompetence. Attempting to do so is also completely inconsistent with the public policy favoring settlement of controversies[3] and Rule of Evidence 5.408.

In sum, the Iowa Supreme Court has decided how a district court is to view a licensing board's statement of charges and settlement agreement. Charges are "assertions of wrongdoing" which have not been proven and a settlement agreement is not a "concession of the merits" nor an admission. Plaintiffs' suggestion that they were denied an "admission of professional incompetence" and that Dr. Otoadese may have testified untruthfully because he had admitted incompetence lacks all merit. The charges and settlement agreement are irrelevant (even if they had pre-dated trial in this case) and there was no admission.

B. The Board Order was entered post-trial.

The second threshold problem is that the Board's Order was approved April 12, 2019—over five weeks after the verdict in this case on March 5, 2019. The Board made its Order public on April 19, 2019—over six weeks after the verdict. As explained further below, under Iowa law this public information is all that ever would have been available to Plaintiffs as all

[3] "The law favors settlement of controversies and, accordingly, 'we have long held that voluntary settlements of legal disputes should be encouraged, with the terms of settlement not inordinately scrutinized.'" *Fees v Mutual Fire & Auto. Ins. Co.*, 490 N.W.2d 55, 58 (Iowa 1992) (citing *Wright v. Scott*, 410 N.W.2d 247, 249 (Iowa 1987).

other Board evidence is privileged.[4] And, if it had been available before trial, it would have been inadmissible. But it was *not* available until *after* the trial was completed in this matter. It cannot support a new trial.

II. There was no "misconduct" during discovery.

The interrogatory is multi-part, asking initially about discipline, statements of charges, letters of warning, or investigations and then, in more detail, asking about licensure suspensions, revocations, terminations, or restrictions. Counsel objected to the interrogatory as seeking information protected by statutory peer review privileges (which was a proper objection as explained below) and then stated "without waiving and subject to these objections, Defendant states no." Counsel did not accurately read the entire list of subjects in the interrogatory and mistakenly answered "no." This was counsel's error, not Dr. Otoadese's. Given activity that could be interpreted as an "investigation," Counsel should have either only objected or alternatively could have stated "without waiving and subject to these objections, see any information that is publicly available or may become publicly available in the future." Given the misreading of the interrogatory, counsel did not supplement or amend the answer. The undersigned represents to the Court that the answer was in no way an intentional or deliberate attempt to mislead Plaintiffs or the Court. It was a mistake.[5]

Defendants respectfully submit the Interrogatory Answer does not represent "misconduct" to support a new trial. In a case cited by Plaintiffs, *Loehr v. Mettille*, 806 N.W.2d

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[4] *See* Iowa Code §272C.6(4) ("all complaint files, investigation files, other investigation reports, and other investigative information in the possession of a licensing board . . .are privileged and confidential").

[5] In the event Plaintiffs suggest that defense counsel intentionally set out to be misleading or inaccurate, Defendants respectfully remind the Court of the offer of proof of Dr. Halloran where it was made clear that his initial testimony elicited by Plaintiffs' counsel to support Plaintiffs' argument that Dr. Halloran was a treating physician was misleading, if not inaccurate. On cross, Dr. Halloran testified that he "absolutely" did not consider himself to be a treating physician before coming to the courthouse the day of his testimony. See Exh. 3 attached to Defendants' Resistance to Plaintiffs' Motion for New Trial at 12:11-13:10 (rough draft of Halloran offer of proof).

270 (Iowa 2011), the Iowa Supreme Court addressed allegations of counsel misconduct and whether the conduct caused prejudice. The Court found neither and reversed the district court's grant of a new trial. *See* 806 N.W.2d at 271.

In *Loehr,* the defense attorney presented an exhibit during trial which was discovered later to be something other than represented to the jury. 806 N.W.2d at 275-76. The plaintiff asserted there was misconduct, warranting a new trial. Instead of finding there was an intentional and deliberate wrongdoing to mislead the jury, the Supreme Court found there was an understandable error. 806 N.W.2d at 279-80 (describing issue as caused by "careless reading and wishful thinking"). The Court declined to disbelieve counsel's explanation of the error and found that it was "implausible" for counsel to have intentionally acted to mislead given that the error could be easily found out. *See id.* at 280 ("if one were going to fabricate an exhibit . . . it seems implausible [to leave information that would disclose the issue]"). The Court found an "absence of real misconduct." *Id.* at 271.

Similarly, in this case, to find "misconduct" the Court would have to disbelieve the undersigned's explanation and find defense counsel intentionally set out to provide inaccurate discovery responses.[6]

The undersigned respectfully submits that there was a mistake—not misconduct.

III. Plaintiffs cannot show prejudice—Board investigative information is not discoverable and not admissible.

Even when there is a finding of misconduct to support a motion for new trial, the Court must still find it caused prejudice in order to grant a new trial. *See Loehr,* 806 N.W.2d at 280 ("Even if there had been misconduct, we cannot agree it prejudiced the Loehrs."); *Mays v. C. Mac Chambers Co.,* 490 N.W.2d 800, 803 (Iowa 1992) (" 'unless it appears probable a different

[6] Determining whether there was "misconduct" is a matter within the Court's discretion. *Loehr*, 806 N.W.2d at 277.

result would have been reached but for claimed misconduct of counsel for the prevailing party,' we are not warranted in granting a new trial").

In order to show prejudice, Plaintiffs must establish they would have been allowed to discover and introduce evidence about the Board investigation. These issues—matters of discovery, the admissibility of evidence, and the presence of prejudice--are matters of discretion. *See Carolan v. Hill*, 553 N.W.2d 882, 886 (Iowa 1996) ("The district court is vested with wide discretion in rulings on discovery matters."); *Graber v. City of Ankeny*, 616 N.W.2d 633, 638 (Iowa 2000) (admissibility of evidence is reviewed for an abuse of discretion); *Mays*, 490 N.W.2d at 803 ("Furthermore, we have held that the trial court 'has considerable discretion in determining whether alleged misconduct, if there was such, was prejudicial.'")

Another threshold applicable legal principle concerns the impact of a privilege on the scope of discovery and the admissibility of evidence. *See Carolan v. Hill*, 553 N.W.2d 882, 886-87 (Iowa 1996) (rejecting narrow reading of peer review privilege); *Chung v. Legacy Corp.*, 548 N.W.2d 147, 151(Iowa 1996)(applying physician-patient privilege at Iowa Code §622.10 to protect information, "We recognize our holding will preclude discovery and admission of relevant evidence. That fact, however, is no reason not to apply the privilege . . ."); *Id.* (quoting *Muller v. Rogers*, 534 N.W.2d 724, 726 (Minn. App. 1995), "'the rules of privilege codify policy determinations that certain relationships and situations are deserving of protection, even if crucial information is thereby withheld.'").

A. Board investigative information is privileged, not discoverable, and not admissible—Plaintiffs would not have been entitled to discovery on this subject.

Plaintiffs acknowledge that Board of Medicine activities are confidential. *See* Supplemental Motion at 3-4 (citing Iowa Code §272C.6(4)); *id.* note 2 (stating "The only

information belonging to the Board of Medicine that is not confidential would be the statement of charges and settlement agreement."). Plaintiffs are correct. Iowa law provides strong confidentiality protection to all Board of Medicine activity leading up to any publicly filed material. *See* Iowa Code §272C.6(4) ("all complaint files, investigation files, other investigation reports, and other investigative information in the possession of a licensing board . . . which relates to licensee discipline are privileged and confidential, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the licensee and the boards, . . . and are not admissible in evidence"); *see also* 653 IAC 24.2(8) (re confidentiality of investigative information).

And the Board strictly adheres to the privileged nature of investigations. The Board's web site includes a consumer brochure, stating:

> The Iowa Board of Medicine is required by state law to maintain the confidentiality of all information related to Board investigations. This includes complaints and investigative reports. Consequently, complainants cannot receive information or be briefed on any aspect of the investigation or how the case is resolved beyond what is presented in public documents about the case.

Feb. 20, 2015 Press Release with Consumer Guide attached. [7]

In light of the impenetrable privilege afforded Board activity other than publicly filed information, Plaintiffs argue that the privilege "does not extend to the licensee (Dr. Otoadese)." Supplemental Motion at 4. Plaintiffs then suggest Dr. Otoadese could have been forced to disclose details about the Board's investigation such as allegations, investigation status, and investigation witnesses. *Id.* In other words, Plaintiffs argue that a patient in a medical malpractice action could obtain Board investigative information pertaining to a defendant physician by simply propounding discovery to the physician, notwithstanding that the

[7] Available at https://medicalboard.iowa.gov/z-index-0 (last accessed May 4, 2019).

information is not discoverable from the Board. This, of course, completely eviscerates the statutory privilege and there are many reasons why Plaintiffs would not have been permitted to obtain information from Dr. Otoadese that they could not obtain from the Board.

Plaintiffs cite no case in which a court allowed a party to skirt a statutory peer review privilege by seeking privileged material from the professional who was subject to the peer review.[8] However, in *Hall v. Broadlawns Med. Ctr.*, 811 N.W.2d 478 (Iowa 2012), the Court acknowledged the problems with the "possession" language in Iowa Code §272C.6(4) which protects "information in the possession of a licensing board." The Court observed: "*At first blush*, it may appear that the statute only protects information 'in the possession of a licensing board or peer review committee.'" *Id.* at 482-83 (emphasis added). The Court continued that "the interpretation of the statute based on possession is problematic" and it approved an argument that protection "runs with the information" as opposed to the possessor. *Id.* at 483. The *Broadlawns* Court discussed the compelling position that it would defeat the public policy behind peer review protections if information protected in the hands of a peer review committee could, as a matter of course, be obtained from others—such as the subject physician. *Id.* at 483-84; *see also id.* at 484 ("the mere fact that a copy of [peer review] is

[8] Other courts have addressed whether peer review information in the hands of physicians was discoverable. *See Hillsborough County Hosp. v. Lopez*, 678 So.2d 408 (Fla. Ct. App. 1996) (finding hospital's disclosure of peer review information to treating physicians did not defeat the privilege and render information admissible); *Nga Le v. Stea*, 286 A.D. 2d 939 (S.C. App. Div. N.Y. 2001)(finding no waiver of peer review privilege because there "was no intentional relinquishment of the privilege" when hospital shared report with one of the physicians involved in the plaintiff's care and subject to the peer review); *Young v. Saldanha*, 431 S.E.2d 669, 671, 674, fn.2 (W.Va.1993)(fact that physician reviewed own peer review (as allowed under the statute) did not defeat privilege in medical malpractice case); *Columbia Park Med. Center v. Gibbs*, 723 So.2d 294, 295 (Fla. Ct. App. 1999)(hospital's disclosure of privileged documents concerning physician privileges to physicians who were not on peer review committee did not defeat privilege).

possessed by a third party should not be determinative of the privilege issue if the privilege is to have any substance"). [9]

Under the *Broadlawns* reasoning, Board investigative information is no more discoverable from Dr. Otoadese than it is from the Board. *See also Cawthorne v. Catholic Health Initiatives*, 743 N.W.2d 525, 528 (Iowa 2007) (§272C.6(4) "should protect the source of information *as well as the person being investigated*") (emphasis added).

Further, to allow a plaintiff in a medical malpractice case to discover Board investigative information from the physician would defeat the purpose for statutory peer review privileges. The purpose of the Board privilege is described in the statute: "In order to assure a free flow of information." *See* §272C.6(4)(a). If Board investigative information is allowed to be discovered from the physician for use in civil litigation, it would chill the free flow of information. In finding a broad peer review privilege in Iowa Code §147.135(2), the Iowa Supreme Court has emphasized the chilling effect on the desired goal of medical evaluation if peer review documents are used in civil litigation. "Peer review privileges encourage an effective review of medical care. . . . Without broad protections, physicians would be very reluctant to participate, knowing the information could easily be revealed in a court of law." *Carolan*, 553 N.W. 2d at 886-87; *see also Bredice v. Doctor's Hospital,* 50 F.R.D. 249, 250 (D.D.C. 1970).

As Justice Appel discussed in *Broadlawns,* the privilege can be viewed as running with the "information" not the possessor. Some courts view it as protecting the process. It would defeat peer review privileges to allow a plaintiff to circumvent the privilege meant to foster the "free flow of information" and obtain privileged information from the subject of the process—the affected licensee. *See, e.g., Marshall v. Planz*, 145 F. Supp.2d 1258, 1273-74 (M.D. Ala.

[9] The *Broadlawns* Court found the records at issue were not privileged but the records were in the hands of a third party and were created for a purpose independent of the licensing board's investigation. *See* 811 N.W.2d at 844-45.

2001) ("The peer review privilege exists to protect the interests of not just one person but rather the entire peer review process (which exists not just for physicians but rather to improve the quality of medical care for all) and *all* those involved, including peer review committees, physicians who participate in them, and others who fall under its protection; it is personal not to one particular person but rather to the entire process and all those involved as a group") (emphasis in original).

Adding to the list of reasons why Plaintiffs would not have been allowed the discovery they suggest is the fact it would involve the confidential and privileged medical information of non-parties. The Board evidence pertains to five patients. *See* Board Order. Thus, it necessarily implicates the privacy interests of non-parties. Those non-party patients did not consent to their medical information being made part of this case. Their identity and medical information is safely protected in the hands of the Board. However, under Plaintiffs' suggestion Board investigative information (which would include the identity and medical information of non-parties) was discoverable from Dr. Otoadese. The physician-patient privilege separately protects such non-party information and would defeat an attempt by Plaintiffs to discovery Board information from Dr. Otoadese.[10] In addition, Dr. Otoadese would be unable to fully respond to the Board evidence given the confidential and separately privileged medical information involving nonparty patients.

For the reasons set forth above, Plaintiffs would not have been allowed discovery on Board of Medicine activity regardless of the answer to the interrogatory. In addition, the evidence would also not have been admissible at trial as discussed below. Thus, any discovery

[10] *See, e.g.,* Iowa Code §622.10; *Head v. Colloton*, 331 N.W.2d 870, 876 (Iowa 1983)(recognizing patient's right to privacy in the context of medical information *and* their identity, based upon the constitution, common law, and the fiduciary duty owed by the provider; and physician and hospital's duty to safeguard privacy); 45 CFR 164. 502 (Health Insurance Portability Act (HIPAA) prohibition against disclosure of protected information).

would not be reasonably calculated to lead to the discovery of admissible evidence. *See* Rule 1.503(1).

B. Even if disclosed to Plaintiffs in discovery, any Board investigation information and any pending charges and settlement agreement would have been inadmissible at trial.

The Board Order was dated *after* trial (April 12, 2019). Thus, any activity leading up to that April 12, 2019 Order would have been in the nature of Board investigative information and such information is not admissible. *See* Iowa Code §272C.6(4).

Assuming without conceding that Plaintiffs would have been entitled to learn in discovery that there was activity in the Board of Medicine prior to trial, that in no way supports the jury would have heard this information. The Iowa Supreme Court has held: "We hold that [§]272C.6(4) prohibits admission of [Board] investigative evidence and that introduction of the IBME investigation . . . was improper." *Cawthorne v. Catholic Health Initiatives,* 743 N.W.2d 525, 528 (Iowa 2007) (remanding case for new trial given trial court erroneous admission of Board investigative information; noting §272C.6(4) contains an "express prohibition from admission.").[11] The second time the Supreme Court ruled on *Cawthorne*, it clarified that a disclosure of statutorily privileged peer review in discovery did nothing to impact the inadmissibility of the privileged information. *See Cawthorne v. Catholic Health Initiatives,* 806 N.W.2d 282, 289-90 (Iowa 2011) (addressing Iowa Code §147.135(2),[12] finding the separate bar against admissibility cannot be waived).

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[11] In *Cawthorne,* the physician had *waived* his right to confidentiality, yet the Iowa Supreme Court found such a waiver did not defeat the statute's prohibition against admission. *See* 743 N.W.2d at 527-28.

[12] Like Iowa Code §272C.6(4), Iowa Code §147.135(2) provides that peer review records "are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release to a person other than an affected licensee or a peer review committee and are not admissible in evidence . . . ." *See* Iowa Code §147.135(2) (protecting "all complaint files, investigative files, reports, and other investigative information relating to licensee discipline or professional competence in the possession of a peer review committee or an employee of a peer review committee.").

Further, Board evidence would have also been inadmissible under Rules 5.402, 5.403, 5.404(b), and 5.408. Even if Plaintiffs had learned of the presence of an investigation and the possibility of future public information from the Board—it would not have been admissible.

Plaintiffs tried unsuccessfully to admit similarly unfairly prejudicial evidence against Dr. Otoadese including the circumstances under which Dr. Otoadese left a prior professional clinic (Cedar Valley Specialists) which involved a lawsuit and settlement and circumstances under which Dr. Otoadese stopped doing open heart surgery at Allen Hospital which involved a lawsuit, settlement, and privileging issues. The Court correctly excluded the evidence. Any Board-related evidence would have been treated no differently.

Rule 5. 402. As discussed above the Board "charges" proved nothing and are merely unproven assertions of wrongdoing and the settlement agreement cannot be interpreted as an admission or concession of wrongdoing. The Board evidence is irrelevant. *See McClure,* 613 N.W.2d at 236-37.

Rule 5. 403. While the *McClure* Court did not exclude board evidence under Rule 5.403 because it found the evidence was not relevant, it clearly acknowledged its prejudicial character. *See McClure*, 613 N.W.2d at 237 (noting the inherently prejudicial nature of evidence of licensing board charges as the "tone of the charges conveys an atmosphere of criminality"); *see also Cawthorne*, 743 N.W.2d at 528 (finding the impact of improper admission of Board investigative information was "so great" as to require a new trial); *Bray v. Hill*, 517 N.W.2d 223, 225-226 (Iowa Ct. App. 1994) (affirming trial court's exclusion of physician's probationary status as more prejudicial than probative under Rule 5. 403).

In *King v. Ahrens*, 16 F.3d 265 (8th Cir. 1994), a medical malpractice plaintiff attempted to introduce evidence that the defendant's medical license had actually been suspended (not the

case here) eight years earlier. *Id.* at 268. The plaintiff in *King* sought to introduce the evidence for impeachment. In affirming the trial court's exclusion of the evidence under Federal Rule 403, the Eighth Circuit found the "danger of unfair prejudice is substantial and immediately apparent" as the "license suspension by its very nature reflects badly" on the physician. *Id.* at 269. In *King*, there was a "great danger" the jury would use the evidence of administrative action[13] to improperly infer that the defendant's conduct in that case was improper. *See id.* at 270.[14]

Further, the Board Order indicates it concerns five patients from 2009-2014. Thus, the evidence would necessarily concern patient incidents that are unrelated to, and disconnected from, the facts giving rise to this case. Evidence of other patient incidents and suits, is not relevant, is highly prejudicial, and should not be admitted. *See, e.g., Lai v. Sagle,* 818 A.2d 237, 247-48 (Ct. App. Md. 2003).

> The fact of prior litigation has little, if any, relevance to whether [the physician] violated the applicable standard of care in the immediate case. The admission of evidence of prior suits, instead of aiding the fact finder in its quest, tends to excite its prejudice and mislead it. . . .[We] cannot conceive of a more damaging event, in a medical malpractice trial, than disclosure to the jury in opening argument that the defendant doctor had previously been sued multiple times for malpractice.

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[13] Few subjects are more prejudicial than evidence of governmental penalties or sanctions. *See Gehl by Reed v. Soo Line R. Co.* , 967 F.2d 1204, 1208 (8th Cir. 1992) (affirming exclusion of a government safety assessment, "There is a danger that government reports, even if not particularly probative, will nonetheless sway the jury by their 'aura of special reliability and trustworthiness.'"); *Firemen's Fund Ins. Co. v. Thein*, 63 F.3d 754, 758-59(8th Cir. 1995) (Federal Aviation Administration reports and investigation would be highly prejudicial as "very likely would cause a jury to feel hostility toward [the defendant]").

[14] *See also State of Iowa v. Henderson,* 696 N.W.2d 5, 10-11 (Iowa 2005) (evidence is unfairly prejudicial when it "'appeals to the jury's sympathies, arouses its sense of horror, provokes its instinct to punish, or triggers other mainsprings of human action that may cause a jury to base its decision on something other than the established propositions in the case'"); *State of Iowa v. Langley,* 2005 WL 1965866 at * 5 (Iowa Ct. App. 2005) (evidence is unfairly prejudicial if it "'would cause the jury to base its decision on something other than the proven facts and applicable law, such as sympathy for one party or a desire to punish a party'"); *Estate of Long v. Broadlawns Medical Center,* 656 N.W.2d 71, 91 (Iowa 2002) (affirming exclusion of information as unfairly prejudicial under Rule 5.403 even though it "may have been relevant" to the issue of future damages).

818 A.2d at 247. This argument applies equally to prior licensing actions arising from other patients.

Evidence regarding the Board activity involving other patients would have led to the trial of collateral issues. Dr. Otoadese could have been forced to simultaneously defend -- or at the minimum explain -- the Board charges involving five patients.[15]

Even if there had been an actual adverse finding by the Board (which there was not), it would have been inadmissible as unfairly prejudicial. In *State v Huston*, 825 N.W.2d 531 (Iowa 2013), the Court reversed a conviction for child endangerment because a DHS caseworker was allowed to testify that a child abuse report had been determined as "founded." Even though the child abuse report arose out of the very same underlying facts as the proceeding at issue in *Huston*, the Court found the evidence irrelevant and unfairly prejudicial. *Id.* at 537-38. As the Court held:

> Telling the jury [about the DHS administrative finding] was unfairly prejudicial due to the risk the jury would substitute [that] determination for its own finding of guilt or would give the determination undue weight.

Id. at 539.[16] Similarly, allowing Plaintiffs in this case to present evidence about any Board activity—even the fact of the charges—would create the very real possibility that the jury would substitute the professional charges for its determination of a breach of the standard or would

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[15] *See Top of Iowa Cooperative v. Schewe,* 135 F.Supp. 2d 969, 975 (N.D. Iowa 2001)(excluding evidence of other lawsuits involving similar grain contracts, finding that each case is dependent upon its own circumstances and that evidence of other claims "presents the serious potential for confusion and for decisions on an improper basis."); *Firemen's Fund v. Thien,* 63 F.3d 754, 758-59 (8th Cir. 1995)(citation omitted) (evidence would require "extended, and irrelevant, litigation [on the collateral issue], and thus would confuse the jury and waste their time and the court's."); *Coast–to-Coast Stores, Inc. v. Womack-Bowers, Inc.,* 818 F.2d 1398, 1404 (8th Cir. 1987)(agreeing that if "other acts" were admitted, the defendant would have the right "to introduce rebuttal evidence . . . confusing the issues and wasting the time of the court and jury."); *Easley v. American Greetings Corp.*, 158 F.3d 974, 977 (8th Cir. 1998) (affirming exclusion of evidence that "would have opened the door to the introduction of evidence on collateral issues").

[16] The Court cited multiple civil cases *and* specifically held that the evidence would not have been admissible even with a limiting or cautionary instruction about the lower burden of proof applicable in the DHS proceeding. *Id.* at 538-39.

give the evidence undue weight. The *Huston* Court recognized the danger when evidence from a "purportedly unbiased state agency" is introduced. *Id.* at 537-38. The appearance of official approval is unfairly prejudicial. *Id.*

Rule 5. 404(b). Board evidence would also be inadmissible under Iowa Rule of Evidence 5.404(b), under which a party cannot introduce character evidence or evidence of "other wrongs or acts" to prove that a person acted in conformity therewith.

The Iowa Supreme Court's discussion of the great danger when "other acts" are admitted into evidence in *State v. Henderson*, 696 N.W.2d 5 (Iowa 2005) is instructive. The Court reversed a conviction based on the prejudice caused by the admission of prior acts. While the majority affirmed that a prior marijuana conviction was relevant, the Court still held the district court abused its discretion in admitting the evidence as it was too prejudicial. *Id.* at 11-12.

The following factors apply to the analysis of the admission of other act evidence:

> "(1) the actual need for the evidence in view of the issues and other available evidence,
> (2) whether there is clear proof showing the other [acts] were committed by the accused,
> (3) the strength or weakness of the prior-acts evidence in supporting the issue sought to be proven, and
> (4) the degree to which the jury will probably be improperly influenced by the evidence."

696 N.W.2d at 11. The *Henderson* Court found the second and third factors supported admission in that case and still found the evidence should not have been introduced. *Id.*

Factor 1: In this medical malpractice case, there would be *no* need for evidence of pending "charges," a pending "settlement," or information about the care and treatment of five patients (when this case involved one patient). As set forth above, such Board evidence is not relevant—charges prove nothing and settlements with licensing boards are not admissions. Nor did this case involve the care of any patient other than Mr. McGrew.

Factors 2 and 3: Here, the "other acts" were not proven at all—much less clearly proven. They were merely assertions of wrongdoing. And in order to determine the strength or weakness of the other acts, there would have to be a trial within a trial—or five trials within this trial—as to each of the five patient situations.

Factor 4: As in *Henderson,* the "degree to which the jury will probably be improperly influenced" would compel exclusion of any Board evidence:

> When prior acts evidence is introduced, regardless of the stated purpose, the likelihood is very great that the jurors will use the evidence precisely for the purpose it may not be considered: to suggest that the defendant is a bad person . . . and that if he did it before he probably did it again.

696 N.W.2d at 12 (citation and internal quotations omitted); *id* at 13 ("It would be extremely difficult for jurors to put out of their minds knowledge [of the prior acts] and not allow this information to consciously or subconsciously influence their decision."); *see also id.* at 14 (J. Lavorato, concurring)("a defendant must be tried for what he did, not for who he is.")(citations and internal quotations omitted).

Rule 5. 408. The Board activity involves settlement—inadmissible under rule 5.408. *See also McClure*, 613 N.W.2d at 236.

IV. Conclusion.

The April 12, 2019 Board of Medicine Statement of Charges and Settlement Agreement was entered by the Board nearly five weeks after the verdict in this case. The charges constitute unproven assertions and the settlement resolved contested issues. There was no finding or admission of professional incompetence. While defense counsel mistakenly responded to discovery on this subject, it caused no prejudice to Plaintiffs. Any evidence other than that made public by the Board (here, after the trial of the case) is privileged, not discoverable, and not

admissible. Licensing board evidence –including investigations, charges, and settlements— have been held by the Iowa Supreme Court to be inadmissible.

For the reasons set forth above, Defendants respectfully request that the Court deny Plaintiffs' Supplemental Motion for a new trial in its entirety.

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CERTIFICATE OF SERVICE
The undersigned hereby certifies that a copy of this document was served upon counsel of record for each party to the action in compliance with Iowa R.C.P. 1.442(b) on: May 6 2019
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Honorable Judge Kellyann Lekar
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IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW AND ELAINE MCGREW, Plaintiffs, v. EROMOSELE OTOADESE, M.D.; AND NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C., Defendants.	LACV130355 **ORDER**

This matter came before the Court for purposes of hearing on post-trial motions on April 17, 2019, and again on July 29, 2019. For purposes of hearing on post-trial motions, the Plaintiffs appeared through counsel, Martin Diaz. The Defendants appeared through counsel, Jennifer Rinden.

An Order for Judgment in favor of the Defendant was entered on March 7, 2019, following a jury trial. A Motion for New Trial was filed on March 7, 2019. That Motion was resisted by Resistance filed March 20, 2019. A Reply to that Resistance was filed on March 21, 2019. The Court then proceeded with a hearing on post-trial motions on April 17, 2019. However, before the Court could rule on the post-trial motions, Plaintiffs filed a Supplemental Motion for New Trial on April 22, 2019, raising additional issues. That Motion was supplemented by Plaintiffs on April 29, 2019. That Motion was resisted on May 6, 2019. On May 7, 2019, the Plaintiffs filed a Motion for Leave to File Supplemental Motion for New Trial and a Reply to the Resistance to the Supplemental Motion for New Trial. A Resistance to the Plaintiffs' Motion for Leave to File Supplemental Motion for New Trial was filed on May 7, 2019. All pending Motions came before the Court for hearing on July 29, 2019.

Plaintiffs' Motion for New Trial filed March 7, 2019, alleged three primary grounds for a new trial: 1. the trial court should have permitted the testimony of Dr. John Halloran; 2. the trial court should have permitted the complete testimony of Dr. Ivo Bekavac; and 3. the trial court should have permitted the Plaintiffs to question the Defendant, Dr. Otoadese, concerning his loss of privileges to perform certain surgery and his termination from Cedar Valley Medical Specialists in 2012.

With regard to this Motion for New Trial, *Iowa Rule of Civil Procedure* 1.1004 requires that the Plaintiffs must establish that the court abused its discretion and that the substantial rights of the moving party were materially affected as a result. Abuse of discretion is the standard used in considering a court's ruling on the admission of a treating physician's testimony. *Hansen vs. Central Iowa Hospital Corp.*, 686 N.W.2d 476 (Iowa 2004). A court is deemed to have abused its discretion only if its decision was based on a ground or reason that is clearly untenable or when the court's discretion was exercised to a clearly unreasonable degree. *Cite Pexa vs. Auto Owners*, 686 N.W.2d 150 (Iowa 2004).

In support of their Motion for New Trial on the basis of the exclusion of the testimony of Drs. Bekavac and Halloran, the Plaintiffs argue that these physicians were disclosed in compliance with *Code of Iowa* Section 66A.11 and that the proposed opinions of these experts were fully disclosed through the medical records of these physicians that were produced through discovery and through Answers to Interrogatories relating to treating physicians. The Plaintiffs, therefore, argue that the treating physicians were fully disclosed and their expected opinions fully provided through full compliance with *Code of Iowa* Section 66A.11 and *Iowa Rule of Civil Procedure* 1.508. The Defendants argue that the designation of these two physicians as experts was provided through the identification of these physicians as "treating physicians" rather than experts retained for purposes of trial and that the Plaintiffs never provided signed expert reports for either physician. For these reasons, the Defendants argue that the testimony of these two physicians should be

limited to only knowledge and opinions held by these physicians as a result of the treatment and care of the Plaintiff and not with regard to standard of care or causation for purposes of this malpractice proceeding.

Each party extensively cites *Hansen vs. Central Iowa Hospital Corp*. as supportive of the position they took both at trial as well as in the course of post-trial motions. During the course of trial, the Court allowed an offer of proof with regard to each of the two treating physicians at issue, conducted extensive hearings with the parties concerning the potential admissibility of the opinions sought by the Plaintiffs, and also issued a formal ruling on the record concerning the admissibility of the expected testimony of these witnesses. This ruling included the Court's analysis and application of the *Hansen* decision to the issue during the course of trial. This Court relies on and incorporates the ruling made by the Court during the course of trial concerning the issue of the testimonies of Dr. Bekavac and Dr. Halloran. This Court continues to believe that the evidentiary determination made during the course of trial is correct under *Hansen* and is also correct under the *Iowa Rules of Civil Procedure* and the *Code of Iowa*. This Court is not persuaded on the Motion for New Trial that the Court's determination concerning the testimonies of Drs. Bekavac and Halloran was an abuse of discretion. Further, this Court incorporates the arguments made by the Defendants in Resistance to Motion for New Trial concerning the fact that even if the Court abused its discretion, the substantial rights of the Plaintiffs were not martially affected as a result of the ruling in light of the testimony that was permitted through Dr. Bekavac and the accompanying exhibits, as well as the testimony of the Plaintiffs' retained expert.

As concerns the Plaintiffs' other allegation of error concerning the admissibility of testimony and evidence surrounding Dr. Otoadese's loss of privileges and termination of his relationship with Cedar Valley Medical Specialists, the Court relies upon the rulings and analyses made on the record during the course of trial and declines to find that either an abuse of discretion occurred or that the Plaintiffs

were materially affected as a result of the rulings. The various evidence offered by the Plaintiffs concerning the ending of the relationship between Dr. Otoadese and Cedar Valley Medical Specialists, as well as Dr. Otoadese's privileges was not relevant to the issues to be decided by the jury in the present case and, further, even if relevant, had prejudicial effect that far exceeded any probative value that that evidence might provide. For the reasons stated above, the Plaintiffs' original Motion for New Trial will be denied.

As indicated, while this Court had the Motion for New Trial originally under advisement, the Plaintiffs filed a Supplemental Motion for New Trial on April 22, 2019. The Motion is brought pursuant to *Iowa Rule of Civil Procedure* 1.1004 concerning new trials. The basis of the Supplemental Motion for New Trial concerned a press release issued by the Iowa Board of Medicine on April 19, 2019, indicating that Defendant, Dr. Otoadese, had reached an agreement with the Iowa Board of Medicine relating to five complaints of professional incompetence occurring between 2009 and 2014. The specifics concerning the complaints are not revealed in the Board of Medicine documents nor are specific patients identified and, therefore, it is impossible for the Plaintiffs or for this Court to know if the Board action involves the Plaintiffs herein.

The Plaintiffs argue that based upon the knowledge gained from the press release by the Iowa Board of Medicine, that the Defendants engaged in irregularity in the proceeding before the Court or misconduct of the prevailing party by failing to disclose, supplement, or correct his Answer to Interrogatory No. 7 which had asked him to disclose whether he had ever been disciplined, had received a statement of charges or letter of warning, or had been investigated by a licensing board. The Plaintiffs go on to argue that the Plaintiffs were prejudiced by the Defendants' failure to disclose or supplement the Interrogatory answer.

In the Supplemental Motion for New Trial, the Plaintiffs further argue that the Combined Statement of Charges and Settlement Agreement represent an admission

by Dr. Otoadese that he was negligent or incompetent. The Defendants resist this argument on the basis that the Iowa Board of Medicine's Combined Statement of Charges and Settlement Agreement expressly states that it "constitutes the resolution of a contested case proceeding" without any specific admission of professional incompetence by Dr. Otoadese.

The Plaintiffs maintain that the Statement of Charges and Settlement Agreement does indeed represent a concession of professional incompetence. Specifically, the Plaintiffs point to Paragraph 6 of the Statement of Charges and Settlement Agreement wherein Dr. Otoadese agrees to be cited for professional incompetency regarding all five patients that are the subject of the Statement of Charges. The Plaintiffs point out that based upon the fact that the Iowa Board of Medicine does not identify the patients who are at issue in the Statement of Charges and Settlement Agreement, it is impossible for the Plaintiffs to know whether or not Paragraph 6 concerning professional incompetence relates specifically to the Plaintiffs in this matter as there is no way for the Plaintiffs to know, without information provided by either the Defendants or the Iowa Board of Medicine, the identity of the patients included in the Statement of Charges and Settlement Agreement. The Plaintiffs point out that this issue becomes critical when viewed in light of the fact that Dr. Otoadese testified at the trial of this matter with regard to the standard of care and whether or not he believed he had breached that standard of care with regard to the Plaintiff. If the Board inquiry and findings include the Plaintiff as a patient, an admission of professional incompetence in the Statement of Charges and Settlement Agreement would be in direct contradiction to the Defendant's testimony at the trial of this matter.

The Defendants cite the Supreme Court's holding in *McClure vs. Walgreen Co.,* 613 N.W.2d 225 (Iowa 2000) as supportive of its argument that a statement of charges and settlement documents should be inadmissible in a civil case involving, as a defendant, the subject of the examining board's statement of charges. The

Defendants further argue that the Iowa Board of Medicine's Combined Statement of Charges and Settlement Agreement was not issued until after the trial in this matter. The Defendants argue that said evidence was not available at the time of trial and, therefore, cannot support a motion for new trial. Further, the Defendants argue, even if the information which made its way into the Combined Statement of Charges and Settlement Agreement was available to the Defendants prior to the date of trial and had been provided to the Plaintiffs, said information would have been inadmissible under the holding of the *McClure* case and, therefore, no prejudice resulted to the Plaintiffs.

In addition, counsel for the Defendants state that any error made in not responding to the inquiry of Interrogatory No. 7 into "investigations" lies with counsel for the Defendants on the basis that counsel did not accurately read the entire Interrogatory and mistakenly answered in the negative. However, counsel points out that even if counsel had appropriately considered the use of the word "investigations" in the Interrogatory as giving rise to a response concerning the investigations which ultimately lead to the Combined Statement of Charges and Settlement Agreement, counsel's only obligation in responding to the Interrogatory would have been to refer the Plaintiffs to any information that is publicly available or may become publicly available concerning any investigations. The Defendants note that with regard to board reviews such as that involved here, Iowa law establishes that the only information that is made public is the fact that charges had been investigated and a settlement had been reached without publicly disseminating any information concerning the investigations.

The Plaintiffs argue that although information held by the Board of Medicine is confidential and not for public dissemination, such confidentiality does not extend to or prevent questioning of Dr. Otoadese on the topic. In response, the Defendants cite *Hall vs. Broadlawns Medical Center*, 811 N.W.2d 478 (Iowa 2012), as support for the argument that public policy would be defeated if information

protected in the hands of a board or peer review committee could be subject to discovery from a third party or the individual being reviewed. The Defendants argue that *Hall* stands for the proposition that the privilege can be viewed as running with the information and not the possessor of the information and that the process itself should be protected.

Finally, Defendants argue that Plaintiffs' Supplemental Motion for New Trial was untimely under *Iowa Rule of Civil Procedure* 1.1007, having been filed on April 22, 2019.

In response to the timeliness issue, the Plaintiffs point out that the press release concerning the Statement of Charges and Settlement Agreement was not made by the Iowa Board of Medicine until April 19, 2019, and that the Plaintiffs filed the Supplemental Motion for New Trial on April 22, 2019, immediately upon learning of the press release. The Plaintiffs argue that this information, which draws into question both misconduct by the Defendant, an admitted mistake by counsel for the Defendant in responding to interrogatory answers, as well as potentially contradictory testimony of the Defendant at the time of trial, constitutes good cause required by *Rule* 1.1007 to extend the timeframe permitted for the filing of a motion for new trial.

This Court is constrained by the specific requirements of *Rule* 1.1007 concerning the filing of a motion for new trial, as well as any extensions which may be granted. Iowa Courts have strictly construed *Rule* 1.1007 and extensions thereof. Iowa Courts have consistently held that motions requesting an extension of time for filing post-trial motions must be filed before the expiration of the original period for filing. The Motion seeking leave to extend the deadline for filing in this matter for the Supplemental Motion for New Trial was not filed until May 7, 2019 which is both after the filing of the Supplemental Motion for New Trial and outside the expiration of the original period for filing a new trial motion.

Without reaching a determination on the merits extended above, the Court finds that the Supplemental Motion for New Trial, as well as the Motion Seeking to Extend the Time to File the Supplemental Motion for New Trial were untimely and, therefore, the Court is without jurisdiction to address the issues raised in those Motions. The Plaintiffs filed the post-trial motion under I*owa Rule of Civil Procedure* 1.1004 (new trial) and *Rule* 1.1007 (time for motions and exceptions). As a result, the Court can only rule on the Motion as presently presented as a Supplemental Motion for New Trial.

For the reasons stated above, the Plaintiffs' Motion for New Trial is DENIED. The Plaintiffs' Supplemental Motion for New Trial is DENIED AS UNTIMELY.

Clerk to send copies to:
Counsel of Record

State of Iowa Courts

Type: OTHER ORDER

Case Number	**Case Title**
LACV130355	W & E MCGREWS VS E OTOADESE ET AL

So Ordered

Kellyann M. Lekar

Kellyann M. Lekar, Chief District Court Judge,
First Judicial District of Iowa

Electronically signed on 2019-12-08 22:52:55 page 9 of 9

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, **Plaintiffs,** **vs.** **EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.** **Defendants**	)	**NO. LACV130355** **NOTICE OF APPEAL**

TO: Clerk of District Court for Black Hawk County, the Clerk of the Supreme Court, and to Counsel for Defendants.

Notice is given that Plaintiffs William and Elaine McGrew appeal to the Supreme Court of Iowa from the final order filed on December 8, 2019 and from all adverse rulings and orders inhering therein, including the adverse jury verdict and entry of adverse judgment.

Dated: December 26, 2019.

Respectfully submitted,

/s/ Martin A. Diaz
MARTIN A. DIAZ 000009676
ICIS AT0002000
1570 Shady Ct. NW
Swisher, IA 52338
319-339-4350 telephone
319-339-4426 facsimile
marty@martindiazlawfirm.com

MARK L. CHIPOKAS PC

By: ___/s/ Mark L. Chipokas_____
Mark L. Chipokas, AT0001418
866 First Avenue NE
P.O. Box 1261
Cedar Rapids, Iowa 52406-1261
(319) 366-7888
(888) 466-1350 Fax
E-mail: mark@mlchipokaspc.com

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

The undersigned certifies a copy of this notice of appeal was served on the 26th day of December, 2019 upon the following persons and upon the clerk of the Supreme Court by EDMS (or by email upon the Court Reporters):

Jennifer E. Rinden
Shuttleworth & Ingersoll
115 3rd St. SE, Suite 500
Cedar Rapids, IA 52401
JER@Shuttleworthlaw.com
Attorney for Defendants

Brittani Meyer
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Court Reporter, First Judicial District
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Clerk, Iowa Supreme Court
Iowa Judicial Branch Bldg.
1111 East Court Avenue
Des Moines, IA 50319

/S/Martin A. Diaz

_____

Cedar Valley Medical SPECIALISTS, P.C.

September 26, 2014

RE: William McGrew
DOB: [redacted]

Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

Ivo Bekavac, MD, PhD

Dept. of Neurology

1753 W. Ridgeway Avenue

Suite 112

Waterloo, IA 50701

319.833.5954

FAX 319.833.5955

HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is approximately 40%. Subsequently Dr. Otoadese performed right carotid artery endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

PAST MEDICAL HISTORY: Hypertension.
SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.
FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.
ALLERGIES: None.
PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.
Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16.
HEENT: Head is atraumatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.
Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.
Heart: Regular rhythm and rate. No murmur.
Lungs: Clear to auscultation and percussion.
Abdomen: Not examined.
Extremities: No clubbing, cyanosis or edema.
NEUROLOGICAL EXAMINATION:
Orientation: He was found to be awake, alert, and oriented X3.
Recent and Remote Memory: Normal.
Attention Span and Concentration: Normal.
Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.
Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.
Sensory Exam: Intact to all modalities.
Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor.
Gait: He is in a wheelchair, unable to walk
Language: Intact.
Fund of Knowledge: Normal.
Speech: Normal.
Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:
1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery.

3. Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:
1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
2. Obtain an MRI of the lumbosacral spine.

3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discrepancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.
4. Reevaluate the patient in one month or earlier as needed.
5. The patient will be notified as well as his family regarding MRI findings.

6. Spent one hour with the patient and his family as well as reviewing records

Ivo Bekavac, M.D., Ph.D.

IB/ts/wkm

IVO BEKAVAC, M.D., Ph.D.

ADDRESS: Department of Neurology
Cedar Valley Medical Specialists
1753 W. Ridgeway Avenue, Suite 112
Waterloo, IA 50701
E-mail: NEUROMARINA@AOL.COM

EDUCATION:

Medical school: University of Zagreb, Croatia
M.D., September 1989

Ph.D.: University of Zagreb/Hahnemann University, Zagreb/Philadelphia
Ph.D. in Neuroscience, April 1995

CLINICAL EXPERIENCE:

Internship - Clinical Hospital Split, Croatia, 1989-90
Internship - Cleveland Clinic, Cleveland, USA, 1994-95
Neurology residency program - Cleveland Clinic, USA, 1995-98
Staff Neurologist – Waterloo, USA, 1998- present

SPECIFIC TRAINING:

EEG/EP/Epilepsy -Cleveland Clinic, Cleveland, USA, 1996-98(6 months)
Minifellowship in Epilepsy - Bowman Gray School of Medicine, 1997
EMG course -Cleveland Clinic, Cleveland, USA, 1997-98 (6 months)
Neurovascular ultrasound (carotid and TCD)-Cleveland Clinic (1 month)
Neurovascular ultrasound course - Bowman Gray School of Medicine, 1998

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology - 2000
American Board of Electrodiagnostic Medicine - 2001
American Society of Neuroimaging – 2002 (MRI/CT & Neurosonology)
Subspecialty Board in Vascular Neurology, ABPN – 2006
Neuroimaging Subspecialty Board, UCNS – 2013

RESEARCH EXPERIENCE:

Student - research program in clinical cardiology, Department of Cardiology, **Clinical Hospital Split, Croatia,** 1986-89
Post Doctoral Fellow - Department of Anesthesia Research, **McGill University, Montreal, Canada,** 1990-91:

-study of activated ion channels using patch clamp technique (neuroscience-electrophysiology)
-study of speed of action of various muscle relaxants using iontophoresis

Research Associate, Department of Physiology, **Hahnemann University, Philadelphia, USA,** 1991-1994:

-effect of cocaine on the somatosensory signal processing using single unit extracellular recording (in vivo)

Resident-cerebrovascular clinical research, Cleveland Clinic, 1995-98

TEACHING EXPERIENCE:

Teaching Assistant-Department of Physiology, **McGill University,** 1990-91
ACLS Course Instructor -First Croatian World Congress, **Croatia,** 1996
Assistant professor of neurology- Medical School Split
Adjunct associate professor of neurosurgery-University of Iowa Hospitals/Clinics

PROFESSIONAL MEMBERSHIP:

American Academy of Neurology, since 1997

LICENSURE:

1. **Iowa**, since 1998
2. **Ohio**, since 1995
3. **Utah**, since 1995

LIST OF PUBLICATIONS:

Papers:

1. Miric D, Rumboldt Z, Tonkic A, **Bekavac I.** (1989). Out-of-hospital sudden death rate: some peculiarities in circadian rhythm. **Medicina** 25:69-71.

2. Rumboldt Z, Miric D, **Bekavac I.** (1988). The rhythm of dying due to heart stroke during the day. The Second Croatian Symposium on Cardiovascular Disease. 54:61-64.
3. Law Min JC, **Bekavac I**, Glavinovic MI, Donati F, Bevan DR. (1992). Iontophoretic study of speed of action of various muscle relaxants. **Anesthesiology** 77:351-356.
4. **Bekavac I,** Waterhouse BD. (1995). Systemically administered cocaine selectively enhances long-latency responses of primary sensory cortical neurons to peripheral stimuli. **J. Pharmacol. Exptl. Therapeut.** 272:333-342.
5. Waterhouse BD, Gould EM, **Bekavac, I.** (1996). Monoaminergic substrates underlying cocaine-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. **J. Pharmacol. Exptl. Therapeut.** 279:582-592.
6. **Bekavac I**, Hanna JP,Wallace RC, Powers J, Ratliff NB, Furlan AJ, (1997). Intraarterial thrombolysis of myxomatous proximal middle cerebral artery occlusion. **Neurology** 49:618-620.
7. **Bekavac I**, Hanna JP, Sila CA, Furlan AJ. (1999). Warfarin and low-dose aspirin for stroke prevention in patients with severe intracranial stenosis.**Journal of Stroke and Cerebrovasc. Diseases** 8:33-37.
8. **Bekavac I,** Halloran JI. (2003). Meningocele induced positional syncope and retinal hemorrhage. **AJNR** 24:838-839.
9. Halloran JI, **Bekavac I.** (2004). Unsuccessful tissue plasminogen activator treatment of acute stroke caused by a calcific embolus. **J. Neuroimaging** 14:385-387.
10. **Bekavac I,** Halloran JI, Frazier S, Sprung J, Bourke DL. (2006). Chiropractic manipulation induced dissection and subsequent aneurysm formation of the internal carotid artery, or if it ain't broke, don't fix it. **J. Explore** 2:150-151.
11. **Bekavac I,** Goel S. (2011). Transient, unilateral, complete, oculomotor palsy in an adult patient with idiopathic intracranial hypertension. **Signa Vitae** 6(1): 44-46.

Abstracts:

1. **Bekavac, I.** (1989). Functional correlate between air pollution and heart disease. Medical Conference 35:1989.
2. Law Min, J.C., **Bekavac, I.**, Glavinovic, M.I., Donati, F. and Bevan, D.R. (1991). Iontophoretic study of speed of action of various muscle relaxants. Anesthesiology 75:A810.
3. **Bekavac, I.** and Waterhouse, B.D. (1992). Physiological actions of cocaine in sensory circuits: I. Enhancement of rat somatosensory cortical neuron responsiveness to vibrisae stimulation. Soc. Neurosci. Abstr. 18:544.
4. Waterhouse, B.D. and **Bekavac, I.** (1992). Physiological actions of cocaine in sensory circuits: II. Drug-induced alterations in receptive field properties of rat somatosensory cortical neurons. Soc. Neurosci. Abstr. 18:544.
5. Kapural, L., **Bekavac, I.**, Trifaro, J.M. and Glavinovic, M.I. (1992). Effect of 4-aminopiridine on bovine chromaffin cell membranes. Soc. Neurosci, Abstr. 18:794.
6. Waterhouse, B.D., Stowe, Z., Jimenez-Rivera, C.A. and **Bekavac, I.** (1992). Influences of cocaine on the response properties of single neurons in

monoaminergically-innervated sensorimotor circuits. Annual Meeting of Drug Abuse, Puerto Rico.

7. Waterhouse, B.D. and **Bekavac, I.** (1992). Cocaine effects on stimulus coding properties of sensory cortical neurons. Annual Meeting of Drug Abuse, Puerto Rico.
8. **Bekavac, I.** and Waterhouse, B.D. (1993). Physiological actions of cocaine in sensory circuits: I. Identification of monoaminergic substrates underlying drug-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. Soc. Neurosci. Abstr. 19-1855.
9. **Bekavac, I.**, Rutter, J.J. and Waterhouse B.D. (1994). Physiological actions of cocaine in sensory circuits: drug influences on signal transmission through rat Pom and VPM thalamic nuclei. Soc. Neurosci. Abstr. 20:982.
10. **Bekavac, I.**, Wallace, R.C., Powers, J., Ratliff, N.B. and Hanna J.P. (1996). Intraarterial thrombolysis of myxomatous proxymal middle cerebral artery occlusion. First Croatian World Congress 1:12.
11. **Bekavac, I.,** Hanna, J.P. and Sila, C.A. (1997). Warfarin and low-dose aspirin for stroke prevention in patients with severe large arterial intracranial stenosis failing monotherapy. Neurology, 49:A289
12. **Bekavac, I.,** Sethi, P., Wong, C.O. and Hanna, J.P. (1998). Utilizing stress Technetium-99m-ECD brain SPECT in the management of intracranial stenosis. Neurology, 50:A400

BOOK CHAPTERS:

Bekavac I, Pathophysiology of neurological diseases. In: Gamulin S, Marusic M. Pathophysiology, fourth edition, Zagreb: Mladost, 1998:830-860.

LECTURES:

Grand rounds, Cleveland Clinic, May 1998: **Excitotoxicity and Stroke**
Clinical Neuroscience Course, University of Split, June 2000
Clinical Neuroscience Course, University of Split, July 2002

Cedar Valley Medical SPECIALISTS, P.C.

October 30, 2014

RE: William McGrew
DOB: [redacted]

Ivo Bekavac, MD, PhD
Dept. of Neurology

753 W. Ridgeway Avenue
Suite 112
Waterloo, IA 50701
319.833.5954
FAX 319.833.5955

Mr. William McGrew comes in for followup regarding stroke as well as lower back pain. He had MRI of the lumbosacral spine read by Dr. Halloran, reviewed personally and showed to the patient. It is remarkable for lateral disc herniation at the level L3-L4 as well as disc bulging at the level L3-L4 as well as L4-L5. Dr. Halloran did over read CTA and felt that there is ICA stenosis of 32%. While doing physical therapy he is doing better, also he has been doing stroke rehabilitation. He has not noticed any improvement. On examination, there is a complete weakness involving left upper and left lower extremity 0/5 unchanged since initial examination September 26, 2014. He has been also complaining of being depressed and also noticed by his family as well. List of medications reviewed. He is not taking any antidepressants. Apparently, he is on clopidogrel as well as aspirin 81 mg for stroke prophylaxis.

IMPRESSION:

1. Status post right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initial carotid artery stenosis 32% according to Dr. Halloran.
2. Intermittent lumbar sensory radiculopathy with symptomatic improvement. No evidence of lumbosacral motor radiculopathy.
3. Depression.

PLAN:

1. Continue with clopidogrel 75 mg a day as well as aspirin 81 mg a day for secondary stroke prophylaxis.
2. Continue physical therapy and stroke rehabilitation.
3. Star the patient on Lexapro 10 mg a day for depression. Potential side effects were explained to the patient as well as his family.
4. Reevaluate the patient in two months or earlier as needed.
5. Multiple questions were answered.

Ivo Bekavac, M.D., Ph.D.

IB/ts/wkm

PLAINTIFFS' EXHIBIT 12

Radiology Results (10/09/14 - 10/01/14) (continued)

Xray consultation referred [136743188] (continued) Resulted: 10/09/14 1426, Result status: Final result

MRI Lumbar spine wo contrast [136743186] Resulted: 10/01/14 1459, Result status: Final result

Ordering provider:	Ivo Bekavac, MD 10/01/14 1303	Resulted by:	John I Halloran, MD
Performed:	- 10/01/14 1423	Resulting lab:	UPH ALLEN MEMORIAL SUNQUEST RAD
Narrative:			

Allen Memorial Hospital MRI Department
MCGREW,WILLIAM M Order No:14AMR3576
1532 HAWTHORNE ST PT. LOC:
WATERLOO, IA 50702 ADMIT HX:

PHONE [redacted]
ADMITTING DR: BEKAVAC,IVO MD DOB: [redacted]
ORDERING DR: BEKAVAC,IVO MD FIN#: 562501743
ATTENDING DR:
CC: THIS COPY TO DR.
MEDICAL RECORD NUMBER: 92371812 DOCUMENT STATUS: Final
Exam Date:10/01/2014
PROCEDURE(S):
MR SPINE LUMBAR WO
CONTRAST USUAL

REASON FOR EXAM:low back pain

TECHNIQUE: Multiplanar, multisequence imaging of the lumbar spine performed.

CLINCAL HISTORY: see above REASON FOR EXAM

CORRELATION: None available.

FINDINGS:

L1-2 level: Negative

L2-3 level: Negative

L3-4 level: Slight disc space narrowing. Very broad-based far right lateral disc herniation. Protruding disc fills inferior recess the right neural foramen and closely approximates right L3 nerve. Moderate bilateral degenerative facet arthropathy. Mild spinal canal stenosis.

L4-5 level: Moderate bilateral degenerative facet arthropathy, grade I spondylolisthesis, symmetric disc bulge, moderate disc space narrowing and small endplate osteophytes. Mild spinal canal and bilateral neural foraminal stenosis.

L5-S1 level: Mild bilateral degenerative facet arthropathy.

IMPRESSION:
1. L3-4 level far right lateral disc herniation, mild spinal canal stenosis and moderate bilateral degenerative facet arthropathy.
2. L4-5 level degenerative facet arthropathy, spondylolisthesis, and mild spinal canal and bilateral neural foraminal stenosis.

Signed by: John I Halloran MD on 10/1/2014 2:56 PM
Report created with Powerscribe 360

ALLEN MEMORIAL HOSPITAL, WATERLOO IA. PAGE 2 of 2
MCGREW,WILLIAM M
MR SPINE LUMBAR WO CONTR DOCUMENT STATUS: Final

Specimen Collection

Type	Source	Collected On
		10/01/14 1423

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
49 - WLARAD	UPH ALLEN MEMORIAL SUNQUEST RAD	Unknown	Waterloo IA	10/13/13 1803 - Present

PLAINTIFFS' EXHIBIT 13

Northern Iowa Cardiovascular & Thoracic Surgery Clinic, P.C.
REGISTRATION FORM

(PLEASE PRINT) Today's Date: 8/18/14

Patient Information: ___ Validated ID ___ Photo ID Refused ___ No Photo ID Available

Last Name: McGrew First Name: William Middle Initial: M
Nickname: Bill Birthdate: [redacted] Age [redacted] Social Security [redacted]
Please Circle:
Marital Status: Single Married Divorced Legally Separated Widowed
Primary Language: English Spanish Bosnian Other
Ethnicity Values: Hispanic Non Hispanic Latino Non Latino Declined
Race: African American Hispanic Caucasian Other Declined
Address: [redacted] PO Box: City: Waterloo State: IA
Zip Code: [redacted] Home Phone: [redacted] Cell Phone: [redacted]
Email Address: Bc918@hotmail.com

Referred By: Dr. John Musgrave Family Doctor: John Musgrave

Emergency Contact Name: Lisa Knipp Relationship: daughter Phone: [redacted]

Student Information: X Not a Student ___ Yes, if yes: ___ Full time ___ Part time
College Name (If attending) ___

Employment Information: ___ Full Time ___ Part Time X Retired ___ Not Employed
Occupation: ___ Employer: ___ Employer Phone: ___

Spouse's Name: Elaine McGrew Spouse's Employer: housewife

Who will be responsible for your account? X Self ___ Spouse ___ Father ___ Mother ___ Other
If not self, please complete: Name ___ SS# ___ Phone: ___
Address: ___ City: ___ State: ___ Zip Code: ___

HEALTH INSURANCE: 4.45
Primary Insurance
Insurance Comp. Name: [redacted] Group#: [redacted] Policy# [redacted]
Policy Holder: ___ Policy Holders Birthdate ___ Policy Holder SS# [redacted]
Insured Employer: ___ Relationship to Patient: ___

Secondary Insurance
Insurance Comp. Name: ___ Group# ___ Policy# ___
Policy Holder: ___ Policy Holders Birthdate ___ Policy Holder SS# ___
Insured Employer: ___ Relationship to Patient: ___

For Patient's under the age of 18:
Father's Name: ___ Mother's Name: ___
Address: ___ Phone: ___ Address: ___ Phone: ___
Employer: ___ Employer: ___

If this is a result of an accident or an injury, please answer:
Date of Injury: ___ Brief Description of Injury: ___

- I authorize you to give me reasonable and proper medical care by today's standards.
- I authorize Northern Iowa Cardiovascular & Thoracic Surgery Clinic, P.C. to release any medical information necessary to process my claim.
- I authorize payment of my medical benefits to Northern Iowa Cardiovascular & Thoracic Surgery Clinic, P.C.
- I understand that I am responsible for any balance due on my account.
- I authorize that a copy of this information to be as valid as the original.

Signature: William M McGrew Date: 8-18-14

DEFENDANT'S EXHIBIT A

Northern Iowa Cardiovascular 001

Northern Iowa Cardiovascular & Thoracic Surgery Clinic PC
146 West Dale St #202
Waterloo, IA 50703
319-233-6211

OFFICE VISIT

DATE:06-30-2016

NAME: William McGrew
DOB: [redacted]
DOS: 08/20/2014

SUBJECTIVE: Patient is here for follow up. He underwent CTA of the carotid arteries as part of the work up of right eye visual disturbance. He is here to review the results of the study and discuss further management.

OBJECTIVE: The CTA showed at least 70% stenosis of the right ICA by a complex plaque. The left ECA is 80% stenotic at the origin. Patient has not reported recurrent symptoms since his last office visit last week.

ASSESSMENT: Symptomatic right ICA stenosis.

Active Medical Problems:
* Carotid Artery Stenosis

Smoking Status: ; Received Cessation Intervention-No

PLAN: Based on his symptoms and the findings of the CTA I recommend right ICA intervention. The options of CEA vs CAS were discussed with the patient and his daughter who was with him during this office visit. In the end patient has elected the CEA. The procedure was described to him and all questions were answered. He will call our office to schedule the right CEA at his convenience.

Eromosele Otoadese, MD

This letter has been auto-generated from our electronic system for expediency and may reflect the nature of such a computer generated report.

REFERRING: John Musgrave MD
FAX#: 319-235-5013
SECONDARY:
FAX:
PRIMARY: John Musgrave MD
FAX: 319-235-5013

Northern Iowa Cardiovascular & Thoracic Surgery Clinic PC
146 West Dale St #202
Waterloo, IA 50703
319-233-8211

CONSULTATION
DATE: 08-28-2014

PATIENT NAME: William McGrew
D.O.B: [redacted]
PCP: John Musgrave MD
REFERRING PHYSICIAN/PROVIDER: John Musgrave MD
DOS: 08/18/2014

PATIENT IS HERE FOR (HX): Patient has no previous history of strokes or carotid artery disease. He relates that he had an episode of transient loss of vision in the right eye several days ago. The episode lasted about a minute and has not recurred. As part of the workup a carotid duplex ultrasound was performed at an outside facility. The study showed 50% stenosis of the bilateral ICAs and critical stenosis of the bilateral ECAs. Patient is now referred to our clinic for further evaluation and management.

CHIEF COMPLAINT: Patient complains of carotid stenosis.

ALLERGIES:
NKDA.

MEDICATIONS:
HCTZ
Dexilant
Aleve
Flomax
Fish oil

PAST MEDICAL HISTORY:
Hypertension.
GERD.
Arthritis.
Carotid artery stenosis.

PAST SURGERIES:
Denies.

FAMILY HISTORY (BLOOD RELATIVES ONLY):
Father,deceased: MI.
Mother,deceased: Lou Gehrig's.
3 brothers,alive: healthy.
5 sisters,alive: cirrhosis(alcohol).
1 brother,deceased: MI.
4 children alive: breast cancer.

SOCIAL HISTORY:
Smoking: Former Smoker
Alcohol: never
Caffeine: average

RISK FACTORS:
age, blood pressure, hypertension

REVIEW OF SYSTEMS:
Hearing Aid, Increased/Excessive Urine, Difficulty Urinating, Urine Frequency, Night Sweats, Dentures, Arthritis, Joint Pain, Weakness, Neck Pain, Numbness, Neurological Weakness
as above otherwise:
Constitutional: No fevers, chills, or significant weight loss.
Eyes: No double vision, blurry vision or diplopia.
Cardiac: No chest pain, palpitation or orthopnea.
Respiratory: No SOB, cough or wheezing.
Gastrointestinal: No abdominal pain, vomiting, diarrhea, heartburn or jaundice.
Genitourinary: No hematuria, polyuria, incontinence.
Psychosocial: No anxiety, depression or bipolar disorder.

VITALS:
Height: 66 Inches
Weight: 192.2 lbs
BMI: 31.019
Pulse: 58
Blood Pressure: 134/68

ADI
4006 Johnathan Street • Waterloo, Iowa • 50701
Phone: 319-236-2700 • Toll Free: 877-ADI-5345 • Fax: 319-236-2714
www.ADIofIowa.com

Name WILLIAM M MCGREW
Phone: (319) 232-2922
DOB: [redacted]
Date of Exam: 8/18/2014

Ordering Physician: EROMOSELE A. OTOADESE MD
JOHN MUSGRAVE MD
Technologist: KS

PROCEDURE: CT ANGIOGRAM OF THE NECK WITH CONTRAST

COMPARISON: None.

INDICATIONS: Carotid stenosis. Visual disturbance. Having Cataract surgery on Wednesday.

HISTORY: 69 year old male with visual disturbance.

TECHNIQUE: Multislice spiral CT angiography was obtained from the level of the aortic arch through the skull base during IV administration of 80ml Isovue 370. Transaxial, parasagittal and coronal images were obtained and the exam was reviewed on a physician 3-D vitrea workstation.

FINDINGS/IMPRESSION:

Brachiocephalic artery: No significant luminal narrowing.

Subclavian arteries:

Right side: Tortuosity proximally without hemodynamically significant narrowing.

Left side: Tortuosity in the proximal segment. No luminal stenosis.

Vertebral arteries:

Right side: Segment 1: Unremarkable. Segment 2: Patent. Segment 3: Patent. Segment 4: Large plaque distally with near occlusion of the proximal third of segment 4.

Left side: V1:Tortuous. V2: Patent. V3: Atherosclerotic disease without significant narrowing. V4: Patent.

Basilar artery: Patent.

Carotid system:

Right side:

CCA: Tortuousity proximally.

Distal segment demonstrates atherosclerotic disease distally extending into the ICA bulb without evidence for significant luminal stenosis.

ICA bulb: Calcified and noncalcified plaque identified leading to a luminal stenosis at the proximal ICA bulb, diameter 1.9mm. The length of the narrowing is approximately 8.8mm. The normal luminal diameter of the postbulbar ICA is approximately 5.2mm. Normal diameter of the distal CCA is 7.9mm. This leads to approximately 65% luminal stenosis compared with the distal vessel (postbulbar ICA). The postbulbar ICA is otherwise patent.

Name WILLIAM M MCGREW
Phone: (319) 232-2922
DOB: [redacted]
Date of Exam: 8/18/2014

Ordering Physician: EROMOSELE A. OTOADESE MD
JOHN MUSGRAVE MD
Technologist: Amber Niemann RT(R) (MR)

The Intracranial ICA: Patent.

Atherosclerotic disease of the intracavernous ICA without significant narrowing.

ECA: No significant luminal stenosis.

Left side:

CCA: Tortuosity in the proximal segment.

Atherosclerotic disease distally.

ICA bulb: Atherosclerotic disease involving the ICA bulb without luminal stenosis.

Postbulbar ICA: There is no significant luminal narrowing.

Intracranial ICA: Atherosclerotic disease without significant luminal narrowing in the intracavernous portion of the ICA.

ECA: There is severe luminal stenosis at the origin of the ECA leading to about 80% luminal stenosis.

Non CTA findings: Small nonspecific bilateral thyroid nodules. Parotid glands unremarkable. Submandibular glands unremarkable. No lymphadenopathy or mass. Airway is patent.

Dictated by: Driss Cammoun, M.D. on 8/18/2014 at 15:28
Transcribed by: BUCK on 8/18/2014 at 15:52
Approved by: Driss Cammoun, M.D. on 8/19/2014 at 9:45

Cedar Valley Medical SPECIALISTS, P.C.

September 26, 2014

RE: William McGrew
DOB: [redacted]

Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

Ivo Bekavac, MD, PhD
Dept. of Neurology

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319.833.5954
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HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is approximately 40%. Subsequently Dr. Otoadese performed right carotid artery endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation. The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

PLAINTIFFS' EXHIBIT 11

PAST MEDICAL HISTORY: Hypertension.
SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.
FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.
ALLERGIES: None.
PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.
Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16.
HEENT: Head is atraumatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.
Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.
Heart: Regular rhythm and rate. No murmur.
Lungs: Clear to auscultation and percussion.
Abdomen: Not examined.
Extremities: No clubbing, cyanosis or edema.
NEUROLOGICAL EXAMINATION:
Orientation: He was found to be awake, alert, and oriented X3.
Recent and Remote Memory: Normal.
Attention Span and Concentration: Normal.
Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.
Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.
Sensory Exam: Intact to all modalities.
Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor.
Gait: He is in a wheelchair, unable to walk
Language: Intact.
Fund of Knowledge: Normal.
Speech: Normal.
Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:
1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.
2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.
3. Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:
1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
2. Obtain an MRI of the lumbosacral spine.

PLAINTIFFS' EXHIBIT 11

3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discropancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.
4. Reevaluate the patient in one month or earlier as needed.
5. The patient will be notified as well as his family regarding MRI findings.

6. Spent one hour with the patient and his family as well as reviewing records

Ivo Bekavac, M.D., Ph.D.

IB/ts/wkm

PLAINTIFFS' EXHIBIT 11

McGrew, William M (MR # 92371812) DOB: 05/30/1945

Clinical Lab Results (continued)

Lab Results

No matching results found

Radiology Results (10/09/14 - 10/01/14)

Xray consultation referred [136743188] Resulted: 10/09/14 1426, Result status: Final result

Ordering provider:	Ivo Bekavac, MD 10/01/14 1346	Resulted by:	John I Halloran, MD
Performed:	- 10/01/14 1500	Resulting lab:	UPH ALLEN MEMORIAL SUNQUEST RAD
Narrative:			

Allen Memorial Hospital
MCGREW,WILLIAM M
1532 HAWTHORNE ST
WATERLOO, IA 50702

General X-ray
Order No:14ARA24244
PT. LOC:
ADMIT HX:

PHONE: [redacted]
ADMITTING DR: BEKAVAC,IVO MD DOB: [redacted]
ORDERING DR: BEKAVAC,IVO MD FIN#: 562501743
ATTENDING DR:
CC: THIS COPY TO DR.
MEDICAL RECORD NUMBER: 92371812 DOCUMENT STATUS: Final
Exam Date:10/01/2014
PROCEDURE(S):
OUTSIDE FILMS FOR REVIEW
OR READING

REASON FOR EXAM:visual disturbance reading of outside films

CONSULTATION/REVIEW OF OUTSIDE FILMS:

I have been consulted to review a CT angiogram performed on William McGrew at ADI on August 18, 2014. The examination was reviewed on a 3-D physician workstation. Volume rendered and maximum intensity projection images were generated and reviewed

FINDINGS:
Aortic arch: Type II aortic arch. Minimal calcific atherosclerosis aortic arch. Minimal atherosclerosis in origin of the left common carotid artery without a hemodynamically significant narrowing. Origin of the right innominate and left subclavian arteries widely patent.

Right carotid: Small focus of calcific atherosclerosis at the origin of ICA producing a 32% diameter stenosis. The post bulbar cervical ICA is widely patent.

The minimal right ICA diameter measures 3.2 cm. Post bulbar normal ICA diameter measures 4.7 cm

Left carotid: Heterogeneous atherosclerosis of the carotid bulb producing 22% maximal lumen diameter stenosis of the proximal ICA. The post bulbar cervical ICA is widely patent. Circumferential noncalcified moderate stenosis of origin of ECA.

The minimal left ICA diameter measures 4.2 mm. Post bulbar normal ICA lumen diameter measures 5.4 cm.

Vertebrals: Short segmental heterogeneous atherosclerotic plaque producing near occlusive narrowing of the distal right vertebral artery and focal noncalcific moderate stenosis of the distal left vertebral artery.

dso

Signed by: John I Halloran MD on 10/9/2014 2:23 PM
Report created with Powerscribe 360

ALLEN MEMORIAL HOSPITAL, WATERLOO IA. PAGE 2 of 2
MCGREW,WILLIAM M
OUTSIDE FILMS FOR REVIEW DOCUMENT STATUS: Final

Specimen Collection

Type	Source	Collected On
		10/01/14 1500

PLAINTIFFS' EXHIBIT 13

CERTIFICATE OF SERVICE AND FILING

The undersigned certifies a copy of the Appendix was filed and served through the Electronic Document Management System on all counsel of record and the Clerk of Supreme Court.

_____/s/ Martin A. Diaz____

CERTIFICATE OF COST

I further certify that, because of use of EDMS, there was no cost associated with the printing and reproduction of this Appendix.

_____/s/ Martin A. Diaz__